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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YJFW
Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245558**

2. STATE VENDOR OR MEDICAID NO. (L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/03/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **78** (L18)

13. Total Certified Beds **78** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(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
Holly Kranz, Unit Supervisor
Date : 10/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Alison Helm, Enforcement Specialist
Date: 10/08/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered October 5, 2018

CMS Certification Number (CCN): 245558

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

Dear Administrator:

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 19, 2018 the above facility is recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

An equal opportunity employer.

Electronically delivered
October 5, 2018

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: Project Number S5558026

Dear Administrator:

On August 29, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 3, 2018. (42 CFR 488.422)
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 28, 2018.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on August 10, 2018 that included an investigation of complaint number H5516035. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 3, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 11, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on August 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 19, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on August 10, 2018, as of September 19, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 19, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of August 29, 2018:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 28, 2018.

In our letter of August 29, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from

conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 28, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 19, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YJFW
Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245558**

2. STATE VENDOR OR MEDICAID NO. (L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/10/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

12. Total Facility Beds **78** (L18)

13. Total Certified Beds **78** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(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: Susan Kalis, HFE NE II — Date: 09/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Alison Helm, Enforcement Specialist — Date: 10/05/2018 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **05/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

August 29, 2018

Good Samaritan Society - Windom
Attn: Administrator
705 Sixth Street
Windom, MN 56101

RE: Project Numbers S5558026, H5338024

Dear Administrator:

On August 10, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required. At the time of the August 10, 2018 abbreviated standard survey this department completed an investigation of complaint number H5516035 that was found to be substantiated.

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

> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and
>
> Appeal Rights - the facility rights to appeal imposed remedies;
>
> Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of

this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 3, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 28, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 28, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Windom is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 28, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions

  are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 9, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING ______ B. WING ______	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on August 6th, 7th, 8th, 9th, and 10th 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted August 6th, 7th, 8th, 9th, and 10th, 2018 and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5558013 was completed and was found to be substantiated at F580 and F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		9/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/07/2018

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
	245558	A. BUILDING ______ B. WING ______	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET WINDOM, MN 56101**

(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 580	Continued From page 1 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING ______ B. WING ______	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to notify the physician of a change of condition after a fall with injury for 1 of 3 resident (R16) and bruising which increased in size with swelling for 1 of 1 resident (R24) reviewed . Findings include: R16's Admission Record face sheet identified R16 was admitted to the facility with diagnosis including unspecified convulsions, muscle weakness and a history of falling. R16's Quarterly Minimum Data Set (MDS) assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. R16 was identified as having no pain and no falls since prior assessment 2/23/18. R16's current care plan, last revised 6/18/18, identified R16 had an actual fall with minor injury R/T (related to) urinary tract infection (UTI) with weakness evidenced by fell times 2 on 6/16/18. The goal was identified as resident will resume usual activities without further incident. Interventions included monitor/document/report PRN (as needed) times 72 hours to health care	F 580	It is the current policy and procedure of GSS-Windom to notify physicians of resident change of condition. On Aug. 8, 2018, the physician for R24 was notified regarding the change in the resident's bruised arm. As of Aug. 27, 2018, the bruise was resolved. The physician for R16 was notified on June 19, 2018 regarding the resident's change in condition after the fall. R16 had a medication review by her primary care physician on Aug. 22, 2018, as well as 4 follow-up orthopedic appointments on July 2, July 11, July 26, and Aug. 23, 2018. All residents who have falls or bruising are at potential risk for this deficient practice. A random audit will be conducted by Sept. 18, 2018, by the Director of Nursing or designee to determine if the physicians have been notified for other residents with changes in condition related to falls or bruising. If the audit shows any changes in condition lacked physician notification, an additional random sample will be audited. Any errors found will be corrected. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing, Sept. 11-14, 2018, regarding our Interact	

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F 580	Continued From page 3 provider for s/s (signs/symptoms) pain, bruises and monitor for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. A care plan problem dated 6/20/18, identified the resident had acute pain/discomfort R/T right ankle fracture with surgical repair. Review of incident report dated 6/16/18, at 5:40 a.m. identified staff went into R16's room after knocking since resident did not put on call light at 5:30 a.m. as per usual. R16 was found sitting on the floor next to the bathroom door frame. Walker next to her. R16 stated she didn't know what happened. Left foot tender to touch, no more swollen than other ankle. R16 not able to bear any weight after assessing ankle, no bruising, able to move ankle back and forth, up and down. Review of incident report dated 6/16/18, at 7:25 a.m. identified resident was taken to the bathroom as she had her call light on. Staff wheeled R16 into the bathroom. R16 used the grab bar to stand up. Staff moved the wheelchair out of the room so to help resident. Resident suddenly let self slip to the floor. The fall was witnessed. The report also identified the root cause of the fall may have been that R16's left foot was hurting since she had fallen 2 hours earlier. R16 was assisted with the mechanical lift and 2 staff onto bed. Pain rating was identified as 2. Review of nursing notes are as follows: 6/16/18, 7:36 a.m. Urine specimen was obtained and sent to WAH (local hospital) for U/A (urine analysis) per Dr's order. Urine is cloudy and	F 580	policy and procedure on appropriate timely notification to the physician of changes in condition related to bruising or a fall, as well as other condition changes. A random audit of residents who have falls or bruising will be conducted by the Director of Nursing Services or designee, 2x weekly for 2 weeks, 1x weekly for 6 weeks, and then every other week for 4 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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amber, foul smell.

6/16/18, 7:48 a.m. Ice pack for swelling to left ankle, every 4 hours as needed apply to left ankle for swelling. Having pain in left ankle.

6/16/18, 8:09 a.m. Resident fell twice within 2 hours. Alert but confused, states "I laid there since 10 p.m. last night". She was in bed at 3:30 a.m. as was checked by this writer (staff). There were no screams coming from room as evidence that there was no obvious way she sat there all night. No tears, flat affect, and skin had no reddened areas of pressure. Left ankle was still painful after administration of PRN Tylenol 650 mg. Called primary doctor since she is confused, urine is very foul and incontinent of urine times 2 in last two hours. Used mechanical lift both times to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks.

6/16/18, 8:13 a.m. After second fall in 2 hours, phoned Dr. to inform she had fallen twice, hurt left ankle, no swelling after 2 hours of initial fall and urine has a foul odor. New orders received (orders were for UA to be done).

6/16/18, 8:15 a.m. Applied ice pack to left outer ankle and was brought to dining room for breakfast. Has no complaints of pain while addresses tablemate's at breakfast.

6/16/18, 9:06 a.m. Ice pack for swelling to left ankle every 4 hours as needed. Apply to left ankle for swelling PRN (as needed) administration was effective not swollen but still

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hurts.

6/16/18, 11:02 a.m. Received phone call from Dr. regarding UA, ordered Cipro, after resident was given one dose it was noted that she had an allergy, call MD informed him she had allergy to medication. He stated no concern and it shouldn't be a problem, just watch her. MD then changed to Macrobid 100 mg twice daily for 7 days.

6/17/18, 12:02 a.m. Due to not able to bear full weight on left ankle after her fall, now using sit to stand times two assist to use bedside commode. Left ankle not swollen but is painful. Applied ice pack to affected area. Call placed to eLTC (electronic long term care Dr. available via video) for an order to medicate with PRN Tylenol.

6/17/18, 12:04 a.m. Acetaminophen tablet 650 mg give by mouth every 4 hours as needed for pain. Acetaminophen not to exceed 3,000 mg per day. Contact provider/practioner if fever is present. Discomfort in left ankle, rates 5 out of 10 pain.

6/17/18, 12:07 a.m. Ice pack for swelling to left ankle, every 4 hours as needed. Has ice pack to left ankle, not swollen but is very tender to touch.

6/17/18, 12:14 a.m. Phoned eLTC in regards to pain in left ankle. Change of condition after her falls 6/16/18. Spoke with (eLTC staff) about no pain med in orders. Will receive orders via fax.

6/17/18, 1:23 a.m. Acetaminophen was given and effective. Follow up pain score 5.

6/17/18, 2:32 a.m. Ice pack for swelling to left

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F 580

Continued From page 6
ankle.

6/17/18, 3:29 a.m. Resident was sitting up on edge of bed as writer (staff) went by. Asked resident to rate her pain, stated it's better now, said feels better than yesterday. Able to bear full weight on affected left foot. Transferred with sit to stand to bathroom.

6/17/18, Acetaminophen 650 mg given for general aches.

6/17/18, 5:33 a. m. Ice pack for swelling to left ankle. Rates the pain in left ankle as 8 out of 10.

6/17/18, 6;05 a.m. Ice pack for swelling. Stated it feels the same.

6/17/18, 7:00 a.m. Acetaminophen 650 mg administration was ineffective pain scale was a 5 "no help at all."

6/17/18, 4:15 p.m. Resident stated I don't think I can stand on my left leg. When transferred with sit to stand lift put most of weight on that leg with no facial grimace or complaints. Denied pain stated it's a little sore.

6/17/18, 9:57 p.m. Resident stated right ankle hurt. Noted a purple bruise on inner right ankle. Will continue to monitor.

6/18/18, 2:03 a.m. Acetaminophen 650 mg given. Up to bathroom able to bear weight on both legs but stated "very painful."

6/18/18, 2:12 a.m. Ice pack applied to both ankles.

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6/18/18 2:16 a.m. Stated "I hurt my right ankle and can't stand on my leg". When placed in sit to stand lift for transfer placed most of weight on that leg with no facial grimace or complaints. Has discoloration of the inner right foot. Stated its a little sore scant swelling bilateral feet.

6/18/18, 2:48 a.m. Ice pack for swelling to left ankle. Took the patchiness away.

6/18/18, 6:58 a.m. Acetaminophen 650 mg given. Pain scale 9. Resident stated no relief to right leg and ankle pain.

6/18/18, 7:30 a.m. Resident complained of severe right leg pain, requesting analgesics.

6/18/18, 8:29 a.m. Pain scale 10. Resident stated no relief from pain.

6/18/18, 11:57 a.m. Acetaminophen 650 mg given. Resident complained of severe right leg and ankle pain.

6/18/18, 1:36 p.m. Acetaminophen 650 mg PRN administration was ineffective. Pain scale 10 resident stated not having any relief.

6/18/18, 8:03 p.m. Acetaminophen 650 mg given.

6/18/18, 11:06 p.m. Acetaminophen 650 mg followup. ineffective pain scale 5 still hurting badly.

6/19/18, 12:03 a.m. Very painful when assessing right foot which now is bruised entirely around the ankle and top of foot is swollen more than last two days. Rather than bear weight on it will use bed pan tonight. Will get X-ray tomorrow.

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6/19/18, 5:09 a.m. Has been using the bed pan to void tonight since she is having so much pain in both feet. Now total lift of mechanical lift with 2 assist to raise up off the bed to change soiled chux. Resident will not turn, insists she's in too much pain to move. Medicated with PRN Tylenol (Acetaminophen) 650 mg for severe discomfort.

6/19/18, 5:10 a.m. Pain is so extreme that the resident needs to be raised in bed using mechanical lift. Noted a bruise on under side of left breast.

6/19/18, 6:39 a.m. Has a whirlpool bath. Two assist out of bed with sit to stand lift. Right foot is swollen +2 and bruised Did have a lot of pain when transferred from bed to wheelchair.

6/19/18, 6:39 a.m. Acetaminophen 650 mg was ineffective. Pain scale 8. Resident continues to rate pain severe.

6/19/18, 9:17 a.m. faxed MD questioning if needs x-ray right foot related to swelling, bruising and pain following fall of 6/16/18.

6/19/18, 2:41 p. m. Fax received from MD that may obtain x-ray of right foot/ankle.

6/19/18, Called family member and informed of x-ray of right foot/ankle scheduled at hospital for 6/20/18 at 11:00 a.m.

6/19/18, 8:10 p.m. Acetaminophen 650 mg given for ankle pain.

6/20/18, 12:19 a.m. Asleep at this time.

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F 580	Continued From page 9 6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain. 6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief. 6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair. 6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resdient complained of moderate pain in right ankle. Requesting analgesics. 6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5. 6/20/18, 4:30 p.m. Discussed pain with residnet and stated not so bad mostly hurts when I lie down and put covers on it. Stated splint supports it and is more comfortable. 6/20/18, 8:18 p.m. Acetaminophen 650 mg given for pain scale of 4. 6/21/18, 3:10 a.m. Acetaminophen 650 mg given. 6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8. 6/21/18, 8:15 a.m. TO hospital for surgery right ankle. 6/21/18, 7:05 p.m. Returned from hospital where she had right ankle repair about 6:30 p.m. She is in a wheelchair. Right foot is splinted and	F 580		

F 580 Continued From page 10 F 580

wrapped with ace. Rates pain at 8 of 10. Will medicate when meds arrive.

6/21/18, 8:30 p.m. Given Ketorolac 10 mg for pain level of 8.

An order from eLTC dated 6/17/18, at 1:00 a.m. identified nurse called requesting order for Tylenol for pain. Patient recently sprained her left ankle, had an order for ice but no order for pain medication. At this time Acetaminophen 325 mg two tablets every 4 hours PRN pain was ordered.

A fax was sent to the MD on 6/16/18, at 5:40 a.m. The fax identified R16 was found on the floor walking to the bathroom with 4 wheeled walker. ROM (range of motion) to left ankle painful when putting pressure on foot, no swelling. Does not want to stand on left ankle. No bruising. The fax was faxed back to the facility on 6/18/18, at 12:20 p.m. with physician comment, "I was called about this, I assume all is now well. Yes? The fax was noted as received back at facility 6/18/18. No reply was sent to the physician regarding pain and swelling of right ankle.

Review of the x-ray results dated 6/20/18, identified a Weber type B distal fibular/lateral malleolar fracture or the right ankle.

Review of pain assessment dated 6/18/18, identified pain associated with a diagnosis or condition, non-pharmacological interventions of ice and rest. The assessment also identified the current medication regime of PRN Tylenol 650 mg and ice PRN was not working.

During interview with the director of nursing (DON) on 8/9/18, at 10:24 a.m. she stated staff

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F 580	Continued From page 11 should have been in touch with the Dr. in a more timely way than faxing. She verified no follow up was done as far as pain medication not being effective, pain status, change in condition and what was being done to treat her. She stated with complaints of pain something obviously changed since there was swelling and bruising. She stated R16 was independent in her room with walking prior to the falls but after the falls she needed to be transferred with mechanical lift and 2 assist. She stated the MD should have been called back on 6/18/18, when we received the fax back and told about the increased pain and swelling and change in condition. She stated when they faxed on the 19th about an x-ray they should have called and not faxed the Dr. to get her in for an x-ray that day. She stated they saw bruising on the 17th, first on the left then on the right which should have been addressed. She stated we have pain meds in the e kit we could have used to make her more comfortable since the Tylenol was obviously not working for pain control. During interview with the attending physician on 8/14/18, at 3:22 p.m. he stated he should have been notified of the increased pain and swelling of the ankle. He stated he was notified of the fall the morning it happened. He stated he did not see the fax from the 16 until Monday morning the 18th. At that time he stated I responded back and asked if everything was ok. He stated I did not hear anything back from them until they asked for an x-ray on the 19th. Review of the policy Notification of Change dated 11/2016, indicates the facility must immediately consult with the residents physician when there is a significant change in the residents physical, mental or psychosocial status and a need to alter	F 580		

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treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment.

R24

R24's quarterly Minimum Data Set (MDS) dated 6/1/18, indicated R24 had severe cognitive impairment and required extensive assist of two staff for bed mobility, transfers and dressing.

R24's Medication Administration Record (MAR) dated August 2018, identified R24 received aspirin 81 milligrams (mg) on a daily basis.

R24 was interviewed on 8/6/18, at 3:30 p.m. and explained he developed a bruise on his left arm, which caused him some occasional pain. R24 did not know how he obtained the bruise, and felt it was getting bigger in size.

R24's skin care plan initiated 7/31/18, indicated R24 had bruising on their left upper arm with interventions for the staff to follow including to monitor the location and size of the bruise, and report abnormalities and/or lack of healing to the physician.

R24's incident report dated 7/30/18, identified R24 developed a bruise on his left arm, which measured 15 centimeters (cm) by 14 cm in size. R24 was recorded as saying, "it hurts."

R24's progress notes identified the following entries:

On 7/30/18, R24 was recorded as having a, "Large discolored area on left upper arm that is dark in color and yellowish towards the posterior

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arm. Resident says, 'My whole arm hurts' ... Etiology unknown." Later on 7/30/18, R24's physician progress note identified R24 had been seen by the physician for the bruising who ordered staff to monitor the area.

On 7/31/18, "Left upper arm is discolored and appears slight swollen. He did not acknowledge any pain in shoulder as he did yesterday."

On 8/5/18, "Update on impaired skin integrity. Bruising on his [left] upper extremity was noted that it had spread down to just distal of the elbow. Swelling noted around the elbow as well. The bruising towards the shoulder is healing and lightening up, starting to get yellowish coloration. He states he has no pain in the arm unless he extends and brings extremity backwards, rated moderate pain. Ice was applied to elbow and pain is being managed with scheduled Tylenol. Will continue to monitor."

On 8/6/18, "[left] arm bruising noted that it had spread down to entire arm. Swelling noted around elbow. Denies any pain."

R24 was observed on 8/8/18, at 7:00 a.m. seated in the hallway in a wheelchair. R24 was assisted to his room, and registered nurse (RN)-D assisted him to remove his shirt. R24 had visible yellow bruising on his front upper shoulder extending down his arm approximately three inches, followed by dark purple, at times almost black colored, bruising extending down and around R24's left arm and wrist area, covering the top of the left hand. In addition, R24's entire left arm was swollen with noticeably localized swelling in the elbow region when compared to his right arm. RN-D stated she had observed the

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bruise when it was first identified on the incident report, however, explained she was not aware if anyone had updated R24's physician about the bruising since it was first identified.

On 8/08/18, at 8:11 a.m. nursing assistant (NA)-A stated she was aware R24 had bruising on his left arm, and he had been complaining of pain when using his left arm to push himself up in bed during cares.

On 8/8/18, at 8:25 a.m. registered nurse (RN)-A stated the bruising "appeared a couple of weeks ago" and she was not concerned with it as, "It's gotta work its way down but its fading." RN-A expressed she was unaware if R24's physician had been notified of the bruising since it developed, however, did not feel it had worsened or that current interventions were not working.

On 8/8/18, at 8:44 a.m. during a phone interview, R24's medical doctor (MD)-A stated he expected the facility to notify him of changes to a resident including when bruising and/or swelling changed so treatment could be considered.

On 8/8/18, at 9:00 a.m. the director of nursing (DON) stated she expected staff to notify the physician when they identified a significant change, which was "something that is more than a natural gravity change." The DON stated MD-A would be coming to the facility today to observe R24's bruising.

On 8/8/18, at 12:32 p.m. during a follow-up interview, MD-A stated he had observed R24's left arm bruising and ordered an ACE wrap and ice to be applied. MD-A stated he "would have expected to have been notified of this change."

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F 580	Continued From page 15 A Notification of Change policy dated 11/2016, identified the staff should consult with the residents' physician when there is any significant change in their physical, mental or psychosocial status.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code the Minimum Data Set (MDS) assessment for weight loss and dental for R69, for pressure ulcers for R51, for prognosis for R41 and for feeding tube/parental/ IV (intravenous) for R62. Findings include: R41 was admitted to hospice services 3/20/18, with a diagnosis of end stage dementia. R41's significant change MDS dated 3/23/18 and quarterly MDS dated 6/15/18, identified R41 received hospice care. The MDS's did not identify R41 had a condition or chronic disease that may result in a life expectancy of less than 6 months as certified by the physician. The hospice physician certification statement identifying R16 was certified as being terminally ill with a medical prognosis that the individual's life expectancy is 6 months or less if the illness runs its normal course, was signed 3/20/18. During interview on 8/8/18, at 9:00 a.m.	F 641	It is the current policy and procedure of GSS-Windom to code the MDS's accurately for all residents. R69, R51, R41 and R62 MDS's will be reviewed and revised as appropriate and resubmitted to CMS by Sept. 10, 2018. All residents are at potential risk for this deficient practice. A random audit will be conducted by Sept. 18, 2018, to determine if there are other residents with inaccurate MDS coding in the last quarter. If the audit shows 30% or more with errors, an additional random sample will be audited. Any errors found will be corrected. To prevent further potential deficient practice, all MDS nurses will be re-educated by the Director of Nursing Sept. 11-12, 2018, regarding appropriate MDS coding. By Sept. 19, 2018, MDS nurses will receive additional training on MDS coding by the Good Samaritan	9/19/18

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F 641	Continued From page 16 registered nurse (RN)-C verified she did not code prognosis on MDS. She stated, "well I have hospice checked on both MDS's, but if we don't have a diagnosis I don't code it." Surveyor stated that the hospice physician signs a certification when hospice is started stating the resident is terminally ill with a medical prognosis of life expectancy of 6 months or less. She stated, "oh well that could be." R51 R51's Order Summary Report dated 8/10/18, identified R51 was admitted to the facility 12/13/17, with diagnosis including peripheral vascular disease. Review of the nursing admission form dated 12/13/17, identified healing ulcer to left heel R51's admission MDS dated 12/17/17, identified the presence of a stage two pressure ulcer. The quarterly dated 3/16/18, significant change dated 4/6/18 and admission dated 4/2/18, MDS's did not identify a pressure ulcer, but other open lesions on foot. Review of a nursing home medication review sheet dated 5/8/17, identified ulcer to left heel. A culture of left heel was completed and a treatment of Medihoney to heel was started. Review of R51's wound nurse follow up note dated 7/24/18, identified history of present illness as including a nonhealing ulcer of left heel. The follow up noted identified wound cultures were completed to left heel ulcer May 21, 2018, which included MRSA (methicillin resistant staphylococcus aureus). Imaging done 6/6/18, identified left lower extremity did not suggest a	F 641	Society Clinical Compliance Consultant. A audit of MDS coding regarding weight loss, dental status, pressure ulcer, hospice prognosis, and feeding tubes, will be conducted by the Director of Nursing Services or designee, weekly for 13 weeks, so that all residents are reviewed. Residents will be audited during their quarterly/annual RAI assessment cycle. Any errors found will be corrected immediately. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 641	Continued From page 17	F 641		

focal level of arterial disease. The wound assessment identified stage 3 left heel pressure ulcer with healing complicated by PAD (peripheral artery disease). Since patients angio on 5/21/18, wounds have been healing well, heel wound now in proliferate phase of healing, continue wound care and pressure relief to heel at all times.

The care plan problem initiated 4/3/18, identified left heel ulcer.

During interview on 8/8/18, at 2:50 p.m. RN-E stated when R51 was admitted to facility the area on his heel was a pressure ulcer. She stated it healed up and then opened up again and we thought it was from vascular disease. She stated we didn't agree with the VA (veterans administration) wound nurse so we didn't code it as a pressure ulcer. She stated they did not contact the VA to clarify if it was a pressure ulcer or vascular ulcer. She stated we used pressure reduction devices for him at all times.

R62

R62's 14 day PPS (prospective payment system) medicare MDS dated 7/19/18, identified R62 had received parental/IV feeding as well as had a feeding tube while a resident.

During interview on 8/8/18, at 2:50 p.m. RN-E stated R62 did not have a feeding tube. She stated oh this must have pulled over from a different MDS when he was here before I guess. He has never had a feeding tube. She verified the MDS was inaccurate.

R69

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F 641	Continued From page 18 R69's admission assessment oral dental assessment dated 5/4/17, identified broken, loose teeth, obvious cavities, many missing teeth and ill fitting dentures. R69's care plan identified the resident has many non restorable decayed and broken teeth. Review of R69's weights identified the following weights: 6/23/18, 194 lbs, 5/25/18 and 201 lbs which was a 3.84% loss in one month and 12/217 209 lbs which was a 7.18% loss in 6 months. R69's annual MDS dated 4/6/18, and quarterly MDS dated 6/29/18, identified none of the above present (broken, loose fitting dentures, likely cavity or broken teeth, edentulous or tooth fragments). The quarterly MDS also identified a weight loss of 5% in the last month or 10% in the last 6 months. During interview on 8/9/18, at 9:01 a.m. RN-C verified the MDS was not coded correctly. She stated the admission oral/dental assessment was correct and the MDS should have been coded accordingly for dental. She also verified that R69 did not have a significant weight loss and that was coded in error. During interview with the DON 8/9/18, at 12:53 p.m. she verified the above MDS's were coded incorrectly. She also stated that in May the VA called it a pressure ulcer. She stated since the wound nurse at the VA was calling it a pressure ulcer, that's what it is and should have been coded as such on the MDS.	F 641		
F 676	Activities Daily Living (ADLs)/Mntn Abilities	F 676		9/19/18

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F 676 SS=D	Continued From page 19 CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.	F 676		

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F 676	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide restorative nursing services for 1 of 3 residents (R48) reviewed for activities of daily living (ADL's) and 1 of 1 resident (R39) reviewed for position mobility. R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to dementia, Parkinsonism evidenced by freezing gait and physical weakness. The care plan interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2-3 times a week. Review of R48's Documentation Survey Reports dated May 2018-August 2018 related to restorative nursing rehab completion indicated the following: May 2018 - one time out of 23 opportunities (5/18/18). June 2018 - 3 times out of 21 opportunities (6/8/18, 6/14/18, 6/19/18). July 3018 - 2 times out of 21 opportunities (7/2/18, 7/31/18). August 2018 - 1 out of 8	F 676	It is the current policy and procedure of GSS-Windom to provide residents with care and services to meet their needs. R48 has passed away. R39's restorative care plan was reviewed and updated as appropriate for positioning mobility by the Case Manager on Aug. 24, 2018. All residents who have restorative care plans are at potential risk for this deficient practice. The plans for all residents were reviewed and updated as appropriate by the Director of Nursing Services by Aug. 24, 2018. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing Sept. 11-14, 2018, regarding restorative nursing care planning; including documentation, evaluation, and completion of restorative plans. On Aug. 28, 2018, the therapy company was updated by the Administrator on the new processes as well. Additionally, a new functional maintenance exercise class will be started on Oct. 1, 2018 for appropriate residents. A random audit of documentation, evaluation, and completion of restorative plans for residents with restorative care plans will be conducted by the Director of Nursing Services or designee, 1x weekly for 12 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure	

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F 676	Continued From page 21 opportunities (8/1/18). When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day. When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know. When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff. When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed	F 676	solutions are sustained.	

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F 676	Continued From page 22 R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. R39's Admission Record dated 8/10/18, identified R39 was admitted to the facility with diagnoses including: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, dorsalgia, muscle weakness and chronic obstructive pulmonary disease. During interview with R39 on 8/7/18, at 9:22 a.m. she stated, I'm supposed to get rehab 3 times a week. I get arm and leg exercises and do the step. I am supposed to have exercises on my band hand too. She further stated I haven't had it at all in August yet. In July I had it 4 times. R39 took me to her computer and pulled up a spread sheet she had made. She had documented on the spread sheet the days in July she received restorative. The days were 2, 5, 24 and 31. She stated a staff member had retired on June 30 and since this occurred it has been really bad. She stated one of the nurses was supposed to be doing it and the nurse is not very good. She stated there is one other girl who is very good but I haven't seen her in awhile. She stated I am supposed to get it Monday, Wednesday and Friday. On 8/7/18, at 11:30 a.m. R39 was observed in the therapy room with aide performing restorative exercises. R39 looked at surveyor, shook her head, shrugged her shoulders and smiled. On 8/9/18, at 2:05 p.m. R39 was asked if she got walked by staff. She laughed and pointed to a June calendar on the	F 676		

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F 676	Continued From page 23 back of her door and stated well look at that, that will tell you. Staff had initialed on June 13, 14, 15, 17 and 18th that resdient was walked. She said that's how much I got walked. I was supposed to walk 1-2 time a day. Now they don't walk me at all. They just didn't and I don't know why. When asked if she was able to walk now she stated I was able to before but don't know if I still can. I haven't done it for a lot of days. R39's quarterly MDS dated 6/15/18, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS also identified a functional limitation in range of motion with impairment on one side, limited assistance of two persons to walk in corridor, walking in room occurred only one or two times with two person assistance, extensive assistance of one person with transfers and bed mobility and supervision of one person with locomotion on and off the unit. R39's quarterly MDS dated 3/23/18, identified R39 required limited assistance of one person with walking in room and in corridor. R39's care plan, last revised 1/5/17, indicated the resident had a need for restorative intervention due to limited physical mobility related to weakness and old CVA (cerebrovascular accident) with right hemiparesis evidenced by inability to independently transfer and ambulate. Goal: resident will maintain current level of mobility of transferring independently in bathroom using handrail. Interventions included active range of motion (ROM) upper extremity (U/E) left with red T-band, 20 repetitions (reps) times 2, 3 times per week, active ROM lower extremity (L/E) left seated exercises with 3# weight 20 reps 3 times per week, active ROM L/E right seated exercises with 0# weights 10 reps 3 times per	F 676		

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F 676	Continued From page 24 week, active ROM Nustep at level 5 10 min 3 times per week, passive ROM to right arm 20 reps as tolerated 3 times per week. The care plan updated 8/2/18, also indicated R39 was unable to ambulate or transfer independently using a total lift for transfers. Review of R39's nursing notes does not indicate why resident was not walked or had restorative per the care plan. A note written 8/8/18, (after surveyor identified issue) identified that due to changes in resident condition she is no longer able to ambulate or use the Nustep as part of her restorative program. Once she has stabilized an order for skilled therapy to evaluate and treat will be obtained to set up further orders for her restorative program. Resident is not realistic about her abilities but this has been explained to her. Review of R39's Documentation Survey Reports dated June 2018-August 2018 related to restorative nursing rehab completion indicated the following: Walking 1-2 times per day: May 2018, 2 times (5//10, 5/29) June 2018, 7 times, (6/4, 6/5, 6/11, 6/15, 6/18, 6/19 and 6/28). July 2018, 2 times (7/3, 7/9). 20 days were marked not applicable. August times 2 (8/1 and 8/2 non applicable rest checked off). Restorative exercises: July 4 days (7/2, 7/5, 7/24, 7/31) 4 refusals. August times 2 (8/7, 8/8). When interviewed on 8/8/18, at 8:00 a.m. physical therapy aide (PTA)-A stated she is aware that restorative is short staffed and did not know how much is getting done. PT-A further indicated she thought nursing was completing it if they didn't have aides.	F 676		

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F 676	Continued From page 25	F 676		

When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day. She stated R39 gets upper and lower exercises, the Nustep, and indicated R39 had never refused restorative from her, but it depended on what staff was working it if she refused. NA-E stated it is best to try approaching R39 before bible study, because she always goes to that. NA-E further explained she sees R39 on Monday,Tuesday, and Thursdays if she isn't pulled to the floor, and indicated a staff member had retired at the end of June so doesn't always get done.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.

When interviewed on 08/10/18, at 12:14 p.m. nursing assistant (NA)-L stated R39 walked with 2 assist 20-30 feet. NA-L thought it had been a couple weeks, and indicated the nursing assistants do the walking as well as restorative.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff. PT-H stated R39 had a program a while back and was

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F 676	Continued From page 26 transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers. When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative sheets. It should be refused or not available. She stated I don't know why she wasn't walked in July. She stated she just started with a change in condition this week. I don't know why she didn't get it in June. We had someone retire end of June so that could be why it didn't get done July and August.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		9/19/18

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F 677	Continued From page 27 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care, shaving, assistance with eating, and oral care was provided for 2 of 3 residents (R4, R48) reviewed for activities of daily living and failed to provide oral care for 1 of 2 resident (R54) reviewed for dental, who was dependent upon staff for assistance with grooming. Findings include: R4's quarterly Minimum Data Set (MDS) assessment dated 7/27/18, identified R4 as having severely impaired cognition per staff assessment. The MDS further identified R4 required extensive assistance with bed mobility, transfers, dressing, toilet use, bathing, personal hygiene, and exhibited physical behavioral symptoms toward others and rejected care. R4's care plan reviewed 8/7/18 indicated the resident required assistance of 1 staff with personal hygiene. The care plan further identified interventions to use if R4 was exhibiting behaviors during cares. During observation on 8/6/18, at 1:56 p.m. R4 was noted to have long soiled fingernails and long white hair on her chin. During observation of morning cares on 8/8/18, at 7:16 a.m., R4 continued to have long nails and chin hair. Nursing assistant (NA)-D looked at R4's long dirty fingernails and stated "oh I wish you'd let us trim your nails". Though R4 was	F 677	It is the current policy and procedure of GSS-Windom to provide residents with care and services to meet their needs. R48 has passed away. R4's nails were trimmed and facial hair was removed by a nursing assistant during survey. R54's oral care was completed by a nursing assistant during survey. ADL care plans for R4 and R54 were reviewed and updated as appropriate by the Director of Nursing Services on Sept. 5, 2018. All dependent residents are at potential risk for this deficient practice. All dependent residents will be audited by the Director of Nursing Services or designee, for inappropriate facial hair, nail care, and oral care by Sept. 19, 2018. Those found with a deficit will receive services that same day. Residents who need assistance with dining will be audited by Sept. 19, 2018, as well to assure proper assistance is received by the Director of Nursing Services or designee. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing Sept. 11-14, 2018, regarding resident grooming; including nail care, shaving, and oral care, as well as assistance with eating and the importance of providing these services. A random audit of grooming and	

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F 677	Continued From page 28 pleasant and cooperative with transfers, dressing and toileting, there was no attempt to trim nails, shave chin hair or provide oral care. During observation on 8/08/18, at 2:43 p.m. R4 was observed in the dining room feeding herself an apple turnover with long dirty nails and long white chin hair. During observation of morning cares on 8/9/18, at 10:19 a.m., R4 continued to have long nails and chin hair. NA-E stated R4 was in a "wonderful mood" and it was a good time to complete cares. Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no offer of shaving, oral cares or nail care. During interview on 8/9/18, at 1:23 p.m. NA-D and NA-E confirmed they had not offered oral care, shaving, or nail trimming to R4 with morning cares. NA-D further indicated R4 required assistance with these grooming tasks and confirmed R4 had long fingernails and chin hair. During interview on 8/9/18, at 2:09 p.m. registered nurse (RN)-C confirmed R4 had long fingernails and chin hair which she described as a "goatee". RN-C indicated R4 has behaviors and will refuse cares, however oral care and shaving should be offered daily before breakfast, and nails trimmed and cleaned when R4 allows. On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to shave, trim nails and provide oral cares prior to breakfast. The DON further stated she had gotten R4 a new razor about one week prior and would expect staff to reapproach or complete tasks when she was cooperative if refused.	F 677	assistance with eating for dependent residents will be conducted by the Director of Nursing Services or designee, 3x's weekly for 4 weeks, 2x's weekly for 4 weeks, and then1x weekly for 4 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 677	Continued From page 29 A facility policy titled Nail Care last revised 10/17 included: keep nails clean and trimmed to promote well-being. R54 R54's quarterly MDS assessment dated 7/6/18, identified R54 as having a Brief Interview for Mental Status (BIMS) of 10 indicating moderately impaired cognition. The MDS further identified R54 with a diagnosis of hemiplegia (paralysis of one side of the body) and required extensive assistance with personal hygiene. R54's care plan last revised 7/4/18, identified a self care performance deficit related to left hemiparesis and inability to independently bathe, dress, or groom. The care plan further identified R54 with several natural teeth broken off. Interventions included staff assistance with personal hygiene and assist to brush teeth after set up twice daily. R54's ADL care area assessment (CAA) dated 11/7/17 indicated extensive to total assist was needed for all ADL's due to hemiplegia. During interview on 8/6/18, at 7:14 p.m. family member- A stated she frequently notices food between R54's teeth and questioned if his teeth were being brushed twice daily. On 8/8/18, at 7:38 a.m. R54 was sitting in his room in a Broda chair. He indicated his teeth had not been brushed. An oral care basin, including a dry toothbrush was observed in the medicine cabinet above the sink in R54's room. On 8/8/18, at 9:43 a.m. R54 was observed to be sleeping in his bed. The oral care basin was observed in the same location with a dry toothbrush. On 8/8/18, at 1:19 p.m. toothbrush remained dry.	F 677		

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F 677	Continued From page 30 During interview on 8/8/18, at 1:31 p.m. NA-C stated oral cares are completed when getting residents up in the morning. NA-C then confirmed she had not brushed R54's teeth this morning stating she had "forgot". On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to provide oral cares per plan of care. A facility policy titled Activities of Daily Living last revised 6/14, included: Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Included in these are the following: 1. General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin , nails and oral care. R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene.	F 677		

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F 677	Continued From page 31 R48's care plan dated 7/7/18, indicated the resident had his own teeth and required extensive assistance of one staff with oral cares. Oral cares to be performed BID (twice a day) as he allows. When interviewed on 8/6/18, at 4:17 p.m. family member (FM)-G stated feeling R48's mouth had seemed quite dirty at times and wondered if staff brushed his teeth. On 8/9/18, at 8:56 a.m. nursing assistants (NA)-D and NA-H were observed providing morning cares for R48. NA's transferred R48 from the recliner where he slept in the dining area, into his wheelchair (w/c) via a standing lift. NA-H then propelled R48 into the tub room. NA-H and NA-D then transferred R48 via the standing lift onto the toilet. NA-D donned gloves and assisted the resident with washing his face then cleaned his hands and fingernails thoroughly. NA-D then obtained a clean washcloth and towel and washed and dried R48's underarms. R48 was swishing his mouth as if he had food or liquid in it. NA-D asked R48 if he needed to spit and brought a towel up to his mouth but the resident wouldn't spit. NA-D doffed her gloves and obtained toothettes to utilize for oral care but did not provide it. NA-D and NA-H then raised resident up and provided pericare; during that time licensed practical nurse (LPN)-A entered the tub room and completed a treatment to R48's bottom after pericare was completed. Once LPN-A completed the treatment, NA's then finished with dressing R48 and transferred him into his w/c. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care.	F 677		

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F 677	Continued From page 32 When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes. Further review of R48's care plan, last revised 7/24/18, indicated the resident required extensive assist of one staff with eating, and to provide the resident with a calm, quiet setting at meal times with adequate eating time. The care plan further indicated R48 holds liquids/food in mouth and needs reminders to swallow. On 8/6/18, at 5:50 p.m. R48 was continuously observed seated in his wheelchair (w/c) at the dining room table in Heritage Court during the supper meal; R48's meal was served at that time. At 6:00 p.m. nursing assistant (NA)-G addressed R48 and asked him if he was going to eat, NA-G was assisting another resident at the same table at that time. NA-G showed R48 that his spoon was on his plate; the resident had his hands wrapped up in his clothing protector at that time. At 6:05 p.m., licensed practical nurse (LPN)-C approached R48 to administer medications that were mixed in pudding. With assistance from NA-G, LPN-C eventually was able to administer the medications in pudding to the resident as he required verbal prompts and encouragement to swallow the medication as would swish it around in his mouth. The resident was observed to take a drink of his fluids independently but other than the pudding that the medications were mixed in, R48 still had not eaten any of his meal nor offered assistance. The resident continued to drink his fluids independently but would not attempt to eat his food. At 6:28 p.m., NA-K sat next to R48 and	F 677		

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F 677	Continued From page 33	F 677		

assisted the resident with eating his fruit, the resident had already consumed all of his fluids at that time. R48 accepted the offered food and ate approximately 50% of his fruit. At 6:40 p.m., NA-K got up from the table and heated up R48's meal in the microwave then set it on the table in front of R48. NA-K did not offer to assist R48 with eating his meal nor offer more fluids to the resident. At 6:55 p.m., R48 picked up his fork with a bite of potatoes on it, raised it slightly, then set it back down on the plate; R48 was not observed to eat any of his food other than the fruit he had been assisted with.

When interviewed on 8/6/18, at 6:55 p.m. LPN-C stated R48 usually ate good on his own but was not having any of it tonight. LPN-C stated they would check with the resident later to see if he would eat a snack.

On 8/9/18, at 9:49 a.m. R48 was continuously observed during his breakfast meal. LPN-A was observed to prepare and set-up breakfast for R48. LPN-A placed R48's plate in front of him then continued to pass medications in the dining room; LPN-A did not offer to assist R48 with eating. At 9:51 a.m., LPN-A asked R48 if he was going to try his breakfast. The resident didn't respond. LPN-A then asked NA-D to assist R48 with eating. NA-D assisted R48 with eating until 10:00 a.m. as went to assist another resident; LPN-A was also administering medications to R48 at that time. LPN-A administered R48's medications in pudding then offered the resident a drink. R48 observed to swish the fluid around in his mouth. When NA-D returned to assist R48, LPN-A instructed NA-D to not attempt to feed R48 more at that time as he wasn't swallowing and didn't want the resident to choke. At 10:17 a.m.,

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F 677	Continued From page 34 R48 was observed to place his glass containing his supplement into his oatmeal; LPN-A continued to administer medications and NA-D and NA-H were assisting other residents. At 10:21, a.m., LPN-A approached R48, removed his glass of supplement from the oatmeal, and attempted to assist the resident with eating. LPN-A offered the resident a drink of orange juice which he accepted. LPN-A prompted R48 to try to swallow the juice rather than swishing it around in his mouth. LPN-A then washed his hands and continued to set-up and administer medications. At 10:26 a.m., R48 was observed with his fingers in his oatmeal; the resident continued to swish has food/fluid contents in his mouth. R48 would spit some of it out at times then wiped his mouth with his fingers. At 10:34 a.m., the pastor entered the dining room and greeted the residents stating they were going to have hymn sing. R48 was observed to take drinks of his Kemps supplement during the activity but did not attempt to feed himself. At 10:49 a.m., NA-E (who had come to replace NA-H on the unit at 10:00 a.m.), approached R48 and cleaned the oatmeal off his hands. NA-E asked the resident if he was finished eating and the resident indicated he was. NA-E also asked R48 if he wanted to finish his juice and the resident indicated that he did. When interviewed at that time, NA-E confirmed that sometimes R48 was able to eat independently and sometimes required assistance. When interviewed on 8/9/18, at 10:59 a.m. RN-C confirmed R48 required extensive assistance of one staff with meals though sometimes he did refuse to eat. RN-C stated if the resident was resistive to assistance would expect that staff would stop and then reapproach. On	F 677		

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F 677	Continued From page 35 subsequent interview on 8/10/18, at 2:41 p.m. RN-C stated the staff on Heritage Court had a lot of people to feed and not enough help. .	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services in a timely manner to ensure pain management was maintained for 1 of 3 residents (R16) who sustained an injury from a fall. R16 suffered harm, severe pain following the injury and was subsequently diagnosed with a fractured ankle; The facility also failed to ensure hospice services were coordinated for 1 of 1 (R41) residents reviewed who was receiving hospice; and failed to monitor edema (fluid retention) for 1 of 1 resident (R7) reviewed for edema in feet/ankles. Findings include: R16's Admission Record face sheet identified R16 was admitted to the facility with diagnoses including unspecified convulsions, muscle weakness and a history of falling.	F 684	It is the current policy and procedure of GSS-Windom to provide quality care to all clients. On June 22, 2018, R16's pain was controlled and continues to be sustained. R16's pain management program was reviewed and updated as appropriate by the Director of Nursing Services and the Case Manager on Aug. 17 and Sept. 6, 2018. R41's Hospice Services have been evaluated and updated to improve coordination of care by the Administrator and Director of Nursing Services, Aug. 13-15, 2018. R7's edema treatment monitoring program was reviewed and updated to include therapy services, by the Director of Nursing Services and the	9/19/18

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F 684	Continued From page 36 R16's Quarterly Minimum Data Set (MDS) assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. R16 was identified as having no pain and no falls since prior assessment 2/23/18. R16's current care plan, last revised 6/18/18, identified R16 had an actual fall with minor injury R/T (related to) urinary tract infection (UTI) with weakness evidenced by 2 falls on 6/16/18. The goal was identified as resident will resume usual activities without further incident. Interventions included monitor/document/report PRN (as needed) times 72 hours to health care provider for s/s (signs/symptoms) pain, bruises and monitor for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. A care plan problem dated 6/20/18, identified the resident had acute pain/discomfort R/T right ankle fracture with surgical repair. An Incident Report dated 6/16/18, at 5:40 a.m. indicated staff had gone into R16's room when the resident had not put on her call light by 5:30 a.m. as was her usual routine. R16 was found sitting on the floor next to the bathroom door frame with her walker next to her. The Incident Report indicated R16 had reported she didn't know what had happened, but had complained of the left foot being tender to touch, but having no significant swelling compared to the other ankle. R16 was not able to bear any weight after assessing the ankle however, there was no bruising, and she was able to move the ankle back and forth, and up and down.	F 684	Case Manager on Aug.16, 2018. The physician reviewed and updated her medications on Aug. 10, 2018. Additional monitoring began on Aug. 10, 2018. All residents with pain related to falls or on hospice services or who have lower extremity edema are at potential risk for this deficient practice. These residents will be reviewed for appropriate services and care plans to meet their needs and provide quality care by the Director of Nursing Services, Case Managers, or Social Workers by Sept. 18, 2018. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing Sept. 11-12, 2018, regarding pain management following a fall, hospice coordination, and monitoring and treatment for lower extremity edema. On Sept. 10, 2018, facility social workers, administration, and nursing management are meeting with the hospice organization to educate them on their responsibilities, the deficient practice, and the new sign-in process being instituted. An audit of pain management needs for every resident who sustains a fall will be conducted by the Director of Nursing Services or designee, for 12 weeks. An audit of hospice coordination for all residents on hospice will be conducted by the QAPI Director or designee, 1x weekly for 12 weeks. An audit of lower extremity edema treatment programs will be conducted by the Director of Nursing Services or designee, 1x weekly for 12 weeks. All	

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F 684	Continued From page 37 Review of an Incident Report dated 6/16/18, at 7:25 a.m. indicated R16 had been assist to the bathroom by staff. The report indicated staff had wheeled R16 into the bathroom and R16 had used the grab bar to stand up. The report indicated staff had then moved the wheelchair out of the room so they'd have room to help the resident however, R16 had suddenly slipped to the floor. The report identified the root cause of the fall may have been related to R16's left foot hurting from a fall 2 hours prior. Following the fall, R16 was assisted with the mechanical lift and 2 staff into bed. At the time she was transferred to bed, her pain rating was identified as a 2 (scale of 1-10 with 10 indicating the worst pain). Nursing notes indicated R16 had a urine specimen obtained per physician order at 7:36 a.m. on 6/16/18 due to cloudy, amber and foul smelling urine. Additional notes indicated at 7:48 a.m. on 6/16/18, R16 required an ice pack for swelling to the left ankle, which would be provided every 4 hours as needed (PRN), and the notes indicated R16 had complained of pain to her left ankle. A nurse's note from 8:09 a.m. 6/16/18, reiterated R16 had fallen twice within 2 hours. R16 was described in the note as "Alert but confused" and had stated, "I laid there since 10 p.m. last night". The nurse's note further indicated the resident was confused because R16 had been observed in her bed at 3:30 a.m. during rounds, and there had been no calling out or screams from her during the night. The nurse documented it was unlikely R16 could have been on the floor all night: "No tears, flat affect, and skin had no reddened areas of pressure...Left ankle was still painful after administration of PRN Tylenol 650 mg (milligrams). Called primary doctor since she is confused, urine is very foul and incontinent of	F 684	audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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	245558	A. BUILDING ______ B. WING ______	C 08/10/2018

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F 684	Continued From page 38 urine times 2 in last two hours. Used mechanical lift both times to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks." 6/16/18, 8:13 a.m. After second fall in 2 hours, phoned Dr. (doctor) to inform she had fallen twice, hurt left ankle, no swelling after 2 hours of initial fall. 6/16/18, 9:06 a.m. Ice pack for swelling to left ankle every 4 hours as needed. Apply to left ankle for swelling PRN (as needed) administration was effective not swollen but still hurts. 6/17/18, 12:02 a.m. Due to not able to bear full weight on left ankle after her fall, now using sit to stand times two assist to use bedside commode. Left ankle not swollen but is painful. Applied ice pack to affected area. Call placed to eLTC (electronic long term care Dr. available via video) for an order to medicate with PRN Tylenol. At 12:04 a.m. the note indicated Acetaminophen tablet 650 mg had been given by mouth. The note further indicated R16 had discomfort in her left ankle, rating it a 5 out of 10 on the pain scale. At 12:07 a.m., the documentation indicated R16 had an ice pack placed due to swelling of her left ankle. The note included, "Has ice pack to left ankle, not swollen but is very tender to touch." an eLTC (telemedicine) note from 6/17/18, with electronic signature at 1:00 a.m., included orders for tylenol 325 mg 2 tablets every 4 hours PRN pain. The note included, "Pt (patient) recently sprained her left ankle. She has an order fo rice, but no order for pain medication. See order above (referring to Tylenol order)." The nurse's note from indicated R16 continued to have swelling and pain in her left ankle	F 684		

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F 684	Continued From page 39 throughout 6/17/18. At 5:33 a.m., R16 described th pain as an 8 out of 10. At 7:00 a.m., R16 stated the Tylenol was "no help at all." At 4:15 p.m. on 6/17/18, R16 stated, "I don't think I can stand on my left leg." However, when transferred with a sit to stand lift, the resident had put most of her weight on the left leg with no facial grimacing or complaints, and had denied pain but stated the ankle was "a little sore." On 6/17/18 at 9:57 p.m., the notes indicated R16 had complained that her right ankle hurt. A purple bruise was noted on her inner right ankle. The note indicated, "Will continue to monitor." Nursing notes from 6/18/18 at 2:03 a.m., indicated R16 had received Tylenol (acetaminophen) 650 mg and "was gotten up to bathroom (BR), able to bear weight on both legs but says, very painful." Subsequently, notes indicated ice packs had been applied to both ankles at 2:12 a.m. At 2:16 a.m., a nurse's note included, "Resident states 'I hurt my right ankle and can't stand on my leg.' When resident is placed in the sit to stand lift for a transfer resident is placing most of her weight on that leg with no facial grimace or any C/O (complaints) noted from the resident. Does have discoloration of teh inner right foot. She has full ROM (range of motion) with that foot & ankle. She did fine with standing and bearing weight on both feet. States, 'It's a little sore is all'." Additional notes included: 6/18/18, 6:58 a.m. Acetaminophen 650 mg given. Pain scale 9. Resident stated no relief to right leg and ankle pain. 6/18/18, 7:30 a.m. Resident complained of severe right leg pain, requesting analgesics. 6/18/18, 8:29 a.m. Pain scale 10. Resident stated no relief from pain. 6/18/18, 11:57 a.m. Acetaminophen 650 mg	F 684		

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F 684	Continued From page 40 given. Resident complained of severe right leg and ankle pain. 6/18/18, 1:36 p.m. Acetaminophen 650 mg PRN administration was ineffective. Pain scale 10 resident stated not having any relief. 6/18/18, 11:06 p.m. Acetaminophen 650 mg followup. Ineffective pain scale 5 still hurting badly. 6/19/18, 12:03 a.m. Very painful when assessing right foot which now, is bruised entirely around the ankle and top of foot is swollen more than last two days. Rather than bear weight on it, will use bed pan tonight. Will get X-ray tomorrow. 6/19/18, 5:09 a.m. Has been using the bed pan to void tonight since she is having so much pain in both feet. Now total lift of mechanical lift with 2 assist to raise up off the bed to change soiled chux. Resident will not turn, insists she's in too much pain to move. Medicated with PRN Tylenol (Acetaminophen) 650 mg for severe discomfort. 6/19/18, 5:10 a.m. Pain is so extreme that the resident needs to be raised in bed using mechanical lift. Noted a bruise on under side of left breast. 6/19/18, 6:39 a.m. Had a whirlpool bath. Two assist out of bed with sit to stand lift. Right foot is swollen +2 and bruised Did have a lot of pain when transferred from bed to wheelchair. 6/19/18, 6:39 a.m. Acetaminophen 650 mg was ineffective. Pain scale 8. Resident continues to rate pain severe. On 6/19/18 at 9:17 a.m., the facility sent a facsimile (fax) to the physician questioning whether R16 should have an X-ray of her right foot related to swelling, bruising and pain following her falls on 6/16/18. A 2:41 p.m., the physician's faxed response indicated approval to get an X-ray of R16's right foot/ankle. The family was called and updated, and informed an X-ray	F 684		

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F 684	Continued From page 41 had been scheduled for 6/20/18 at 11:00 a.m. 6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain. 6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief. 6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair. 6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resident complained of moderate pain in right ankle. Requesting analgesics. 6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5. 6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8. 6/21/18, 8:15 a.m. To hospital for surgery right ankle. 6/21/18, 7:05 p.m. Returned from hospital where she had right ankle repair about 6:30 p.m. She is in a wheelchair. Right foot is splinted and wrapped with ace. Rates pain at 8 of 10. Will medicate when meds arrive. An order from eLTC dated 6/17/18, at 1:00 a.m. identified nurse called requesting order for Tylenol for pain. Patient recently sprained her left ankle, had an order for ice but no order for pain medication. At this time Acetaminophen 325 mg two tablets every 4 hours PRN pain was ordered. The record further indicated a fax had been sent to the MD on 6/16/18, at 5:40 a.m. identifying R16 had been found on the floor after walking to the bathroom with a 4 wheeled walker. The fax indicated R16's ROM (range of motion) to left ankle was painful when putting pressure on foot, but there was no swelling. The fax included, "Does not want to stand on left ankle. No bruising." A return fax from the physician was	F 684		

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F 684	Continued From page 42 received 6/18/18, at 12:20 p.m. with physician comment, "I was called about this, I assume all is now well. Yes?" No reply was sent to the physician regarding pain and swelling of right ankle. Review of a pain assessment dated 6/18/18, indicated R16 had pain associated with a diagnosis or condition and identified non-pharmacological interventions to include: ice and rest. The assessment also identified the current medication regimen of PRN Tylenol 650 mg and ice PRN was not working. X-Ray result findings of the right ankle dated 6/20/18 indicated: "Findings: "... a Weber type B distal fibular fracture. Probable medial malleolar fracture. Allowing for osteopenia no acute displaced facture is seen in teh mid to forefoot. of the right ankle." During interview with the director of nursing (DON) on 8/9/18, at 10:24 a.m. she stated staff should have been in touch with the doctor in a more timely way rather than faxing. The DON verified no follow up was done to ensure the pain medication was effective, or to notify the doctor of the resident's pain status and change in ADL ability due to the pain. The DON stated with complaints of pain something obviously changed since there was swelling and bruising. In addition, the DON confirmed R16 had been independent in her room with walking prior to the falls but after the falls required transfer assistance with a mechanical lift and 2 assist. As such, the DON said the doctor should have been notified after his fax had been recieved 6/18/18 to notify him of R16's increased pain, swelling and change in condition. The DON stated the nurse should have called the physician about getting an X-ray instead of faxing on 6/19, and should have tried to get the resident in for the X-ray sooner. She	F 684		

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F 684	Continued From page 43 stated they saw bruising on the 17th, first on the left then on the right which should have been addressed and added, "we have pain meds in the E-kit (emergency kit) we could have used to make her more comfortable since the Tylenol was obviously not working for pain control." During interview R16's doctor on 8/14/18, at 3:22 p.m. he stated he should have been notified of the increased pain and swelling of the ankle. He stated although he was notified by fax of the fall the morning it happened, he did not see the fax until Monday morning 6/18/18 at which time he'd responded back and asked if everything was "ok". He stated, "I did not hear anything back from them until they asked for an X-ray on the 19th." COORDINATION OF HOSPICE SERVICES: The facility failed to coordinate hospice services for R41. R41's medical director had signed a certification/recertification of hospice services on 6/7/18. The form indicated hospice services had originally been initiated 3/18/18, due to R41's diagnosis of senile degeneration of the brain. R41's significant change MDS dated 3/23/18, indicated R41 had severely impaired cognition, and total dependence with all activities of daily living (ADLs). The MDS also indicated R41 was receiving hospice services. R41's care plan revised 4/3/18, indicated R41 had a terminal prognosis related to end stage dementia and was receiving hospice care. Interventions included: assess resident and family coping skills, contact hospice staff for support as needed, work with nursing staff to provide maximum comfort for the resident. A clip board with numerous papers attached was observed at the nurses station. Under numerous papers was a paper that said ATTENTION FACILITY STAFF! "[R41] is under the care of	F 684		

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F 684	Continued From page 44 (name of hospice)." The team was identified as nurse, social worker and chaplain. No aide or volunteer was identified. A second page was located on the clip board under that page: "(name of hospice) nurse-weekly visits on Monday, Aide-provides AM (morning) ADL cares Monday thru Friday. Chaplain/SS (social service) Thurs/Fri (Thursday/Friday). No patient name was identified on the second page. The hospice agency plan of care provided by the facility also failied to include a hospice visit schedule on it. During observation on 8/8/18, at 7:05 a.m. a hospice aide was present giving R41 a bath. At 7:43 a.m. R41 was sitting at the breakfast table being fed by a facility staff member. The staff stated the hospice aide left after giving R41 her bath. During interview on 8/8/18, at 8:13 a.m. nursing assistant (NA)-D stated, "we don't know what they [hospice staff] are going to do when they come. For instance, today they couldn't feed her because they had to go do something else. Sometimes they give her a bath and feed her, sometimes they just feed her. We never know. We don't know days or times they will come either. Sometimes they tell us, sometimes they don't. I think they are supposed to come 3 days a week or something, but they maybe only come two. We never know what time, sometimes it's 6 a.m. when they are supposed to be her at 8. Other times, they've come at like 4 in the afternoon too." During interview on 8/8/18, at 8:30 a.m. NA-F stated, "you never know around here when they will come. Sometimes they come and then they have to leave because they have to go somewhere else so they don't do everything they are supposed to. If they can't make it they don't tell us they just come another day."	F 684		

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F 684	Continued From page 45 During interview on 8/8/18, at 9:00 a.m. RN-C stated, "There is a calendar at the desk. The aide comes every morning Monday through Friday between 6 and 8 a.m. They have a chaplain and a social worker that come in the later part of the week. The nurse comes on Tuesday, she was here yesterday. She [R41] has a volunteer that comes a lot. If they can't make it they don't tell us they just come another day. My hospice people are stable so I'm not concerned about it. If they do let the nurse know they aren't coming then the aides should be told that too." During interview on 8/8/18 at 9:28 a.m., licensed practical nurse (LPN)-B stated she did not know where the calendar for hospice was located in order to know when hospice was coming. RN-B came onto the unit during the interview and stated, "The calendar is under the clip board". During observation on 8/9/18, at 7:47 a.m. a hospice aide (HA)-A was observed in the dining room feeding R41. At that time, HA-A stated, "We are here 5 days per week for [R41]. I come at 5:30 a.m. because I have another patient here also. We have 5 different aides and we all have different schedules. It depends on where the clients are, and who has them, as to what time they come. If I do morning cares then I don't feed, and if I don't do morning care then I feed her breakfast, play music, curl her hair. Normally her bath is done so then I feed her. Yesterday I had to go because we were short, someone called in so we had to split visits up so I had to go. I don't talk to the staff really unless something is out of the ordinary. I just come in and go directly to her room to help her. If I need to tell them [staff] something I will, such as if something is different or out of the ordinary. During interview with the DON on 8/9/18, at 12:47 p.m. she stated, "The hospice should give us a	F 684		

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F 684	Continued From page 46	F 684		

schedule. We need to tell them we don't know when their people are coming. That is not good communication for continuity of care."

EDEMA MONITORING

R7's diagnosis report dated 8/10/18, included diagnoses of edema, macular degeneration (an eye disease that causes vision loss), and dementia.

R7's quarterly Minimum Data Set (MDS) assessment dated 5/4/18, identified R7 as having a Brief Interview of Mental Status (BIMS) of "8" indicating a moderately impaired cognition. The MDS further indicated R7 required assistance with bed mobility, transfers, dressing, toilet use, hygiene, and bathing.

R7's care plan reviewed 5/17/18, indicated R7 required assistance with activity of daily living (ADL's) related to impaired vision, muscle weakness, and impaired cognition. The care plan did not address the residents bilateral edema in her feet/ankles.

Review of R7's current physican orders dated 6/12/18, included Lasix (a medication to reduce extra fluid in the body) 80 milligram (MG) daily for edema.

During observation on 8/8/18, at 12:50 p.m., R7 was observed to have bilateral edema in her feet and ankles. The resident was sitting in a recliner chair in her room with her feet resting on the floor. The resident had velcro closing shoes and grippy socks on, however there was visible indentation to R7's ankles from the grippy socks. The right ankle also had a reddened appearance.

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F 684	Continued From page 47 During observation on 8/9/18, at 8:46 a.m. nursing assistant (NA)-C transferred R7 into a recliner chair. R7 was wearing socks and shoes, however visible bilateral edema to ankles was noted, and her feet remained on the floor when NA-C left the room. During interview on 8/8/18, at 10:04 a.m. NA-C confirmed R7 had edematous ankles. NA-C further stated there were no specific interventions for the edema but indicated R7 would elevate her feet if she wanted to. During interview on 8/8/18, at 1:09 p.m. registered nurse (RN)-B indicated R7 had long standing edema to her lower extremities. RN-B confirmed there was no formal monitoring in place for the edema. During observation and interview on 8/9/18, at 2:22 p.m., R7 was sitting in her recliner chair with her feet on the ground. RN-C assessed R7's lower extremities stating they were cool and dry. RN-C further verified right lower extremity had a redness present but no warmth or discomfort noted from R7. RN-C identified R7 had two plus pitting edema (swelling that is significant enough to cause an indentation of 3-4 millimeters deep in the skin when depressed with a finger) in right ankle and foot and one plus pitting edema (indentation of 2 millimeters) in left ankle and foot. RN-C stated R7 had refused to wear support stockings in the past, however indicated R7 should have other interventions in place to manage and monitor the edema, confirming there was nothing in place at this time. During interview on 8/10/18, at 2:48 p.m. the	F 684		

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F 684	Continued From page 48 director of nursing (DON) confirmed R7's lower extremity edema should be monitored with interventions in place to control it. A facility policy titled Care Plan revised 11/16, indicated each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure relieving	F 686	It is the current policy and procedure of GSS-Windom to assess and provide appropriate interventions for all residents	9/19/18

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F 686	Continued From page 49 interventions for 1 of 1 resident (R48) with two current facility acquired stage 2 pressure ulcers. This deficient practice resulted in actual harm for R48 when one stage 2 pressure ulcer worsened and a new stage 2 pressure ulcer developed. Findings include: R48's Admission Record Face Sheet, indicated R48 had been admitted to the facility on 1/5/18, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18, indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The MDS further indicated R48 was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, and utilized a pressure relieving device in bed and chair. R48's current care plan, last revised 7/24/18, included: The resident has potential for pressure ulcer development R/T (related to) needs assist with mobility and frequent bladder incontinence. The interventions included: Pressure reduction mattress and cushion in w/c (wheelchair). Notify nurse immediately of any new areas of skin breakdown; redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R48's Mobilization Support Data Collection Tool dated 6/28/18, indicated the resident had enough torso strength to maintain an upright, seated	F 686	at risk for pressure sores. R48 was assessed and provided with interventions for pressure sores the week of survey by the Case Manager and Director of Nursing Services. R48 has since passed away. All residents with pressure sores are at potential risk for this deficient practice. These residents will be assessed with appropriate interventions put in place as appropriate by Sept. 18, 2018 by the Case Managers and Director of Nursing Services. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing Sept. 11-14, 2018, regarding comprehensive assessment of and the implementation of appropriate interventions for preventing and treating pressure sores. An audit of pressure sore assessment and interventions for each resident with a pressure sore will be conducted by the Director of Nursing Services or designee, 1x weekly for 13 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 686	Continued From page 50 position, used a sit-to-stand lift with assist of two staff when transferring between surfaces, and required assist of two staff with a walker for ambulation. The data did not indicate what support R48 needed to position up in bed, turn in bed from side-to-side, to move from lying to sitting on the edge of bed, or to move from a seated position on the side of the bed to a lying or reclined position in bed. The data indicated: Does not sleep in a bed. R48's quarterly Braden Scale for Predicting Pressure Sore Risk dated 6/28/18 was scored as 13, indicating R48 was at moderate risk for skin breakdown. In addition, R48's recent Skin Observation form dated 8/5/18, indicated: no skin conditions observed. On 8/8/18, R48 was continuously observed from 7:15 a.m. until 9:38 a.m. lying in a recliner in the dining area. Staff were assisting other residents in and out of the dining room and providing breakfast during that time. R48 had one leg on the footrest of the recliner with the other leg hanging down with one shoe off and one shoe on. R48 would move his legs periodically and would make moaning/humming type sounds. At 9:38 a.m., nursing assistant (NA)-D approached R48 and asked if he was ready to get up; the resident responded he was. NA-D and NA-F pivot transferred R48 into his wheelchair (w/c) which had a pressure reducing waffle air cushion on the seat. The resident's recliner did not have a pressure reducing cushion on the seat. NA-D then propelled R48 into the tub room to assist him to the toilet. NA-D indicated the night aide (NA-J) had completed R48's morning cares earlier, and had assisted R48 to the toilet around 6:00 a.m. (approximately 3 1/2 hours earlier). NA-D and	F 686		

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F 686	Continued From page 51 NA-F were observed to transfer R48 onto the toilet. When R48 was finished on the toilet, NA-D and NA-F stood the resident up to provide peri-care. R48's bottom was observed to have 2 small open red areas, one on the coccyx and one on the right upper buttock near the crease; the areas were circular and approximately 0.5 centimeters (cm) in diameter. When asked if the areas were new, NA-D stated they were new to her. The NAs then sat the resident back down onto the toilet and alerted the nurse to come into the tub room to observe the resident's bottom. Licensed practical nurse (LPN)-B entered the tub room and confirmed R48 had 2 open areas on his bottom. LPN-B stated the areas were new to her but that she would have to research the resident's medical record to make sure they had not been there prior to today. LPN-B then instructed the NA's to feed the resident breakfast first prior to providing treatment or measuring the open areas. When interviewed immediately following the observation, NA-D confirmed R48 always slept in the recliner in the dining area. NA-D stated when the resident first came to the facility they would attempt to have him sleep in the recliner in his room as the resident had slept in a recliner at home however, NA-D stated R48 would crawl out of the recliner in his room and come out to the recliner in the dining area to sleep. NA-D stated per R48's preference, they continued to have him sleep in the recliner in the dining area. When interviewed on 8/8/18, at 10:27 a.m. NA-D stated staff try to reposition R48 every 2 hours though sometimes it can be longer. NA-D further stated sometimes the resident was resistive to repositioning, and other days he was up and on the move.	F 686		

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F 686	Continued From page 52 A facsimile (Fax) to R48's physician dated 8/8/18, and sent at 11:34 a.m. indicated: "[R48] has an open area on his coccyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or soiled." A fax response from the physician, dated 8/9/18 at 10:07 a.m., was reviewed with physician approval of this plan. On 8/8/18, at 1:10 p.m. R48 was observed laying in the recliner in the dining room with his knees bent and eyes closed. When interviewed at that time NA-D confirmed the resident had been transferred into the recliner at approximately 12:50 p.m. NA-D further confirmed LPN-B had not yet measured or done any type of treatment to the open areas on R48's bottom as she was awaiting direction from the registered nurse case manager (RN)-C. When interviewed on 8/8/18, at 1:57 p.m. LPN-B stated she had applied a hydrocolloid dressing to the open area on R48's coccyx. LPN-B stated the dressing was large enough to cover the smaller superficial reddish areas below the coccyx as well. When asked about the other open area on R48's right upper buttock, LPN-B stated not realizing the resident had more than one open area. LPN-B then stated she would be back to work tomorrow morning and could look at it then. LPN-B confirmed she had not measured the open area on R48's coccyx as staff was having a difficult time keeping the resident standing during the treatment. LPN-B stated the open area on the coccyx was approximately 0.5 cm round in diameter. LPN-B confirmed R48 had never utilized a pressure reducing cushion when in the recliner.	F 686		

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F 686	Continued From page 53 On 8/9/18, at 8:56 a.m. NA-H and NA-D were observed getting R48 up out of his recliner to perform morning cares. The NA's utilized a standing lift (a mechancical lift) to transfer R48 into his w/c. R48's w/c had a pressure reducing waffle air cushion on the seat with very little air in the cushion; the recliner did not have a pressure reducing cushion on the seat. R48 was then propelled into the tub room to be toileted and assisted with cares. NA's utilized the standing lift to transfer the resident onto the toilet, NA-H removed R48's brief, which was soiled with bowel movement. NA-D asked NA-H if there was a duoderm dressing on the resident's bottom and NA-H informed her there was not. After assisting R48 with washing up and changing clothes for the day, NA-D and NA-H then raised the resident up to a standing position with the lift and provided peri-care. R48 hollered out "Ow!" while his bottom was being cleansed. R48's bottom was observed; there was no dressing covering the resident's coccyx. R48 had two open areas on the coccyx, an upper open area on the coccyx was new since the observation on 8/8/18. The lower open area on the coccyx was larger with white slough covering the wound bed. The area on the right upper buttock near the crease had decreased in size, was reddened and appeared to be closed, there was another small reddened area next to it. NA's put the call light on to alert the nurse. LPN-A entered the room and measured the open area's on R48's coccyx. The new upper area on the coccyx measured 1.0 cm and was circular, the lower open area measured 1.8 cm x (by) 1.0 cm. LPN-A also identified the small reddened areas on R48's right buttock though felt they were scratches. LPN-A applied skin prep to R48's coccyx then covered the open areas with a hydrocolloid dressing. NA-H then	F 686		

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F 686	Continued From page 54	F 686		

finished dressing R48 and transported him to the dining room for breakfast.

When interviewed on 8/9/18, at 10:49 a.m. NA-E stated R48 was to be repositioned every 2 hours just like all the other residents on the unit.

When interviewed on 8/9/18, at 10:55 a.m. LPN-A stated he was told when coming on duty today that RN-C wanted him to take a good look at R48's bottom as it had been reported there was an open area. LPN-A stated other than that there were no new interventions to inform RN-C of, or any further reports of what he'd observed, but that she'd (RN-C) take it from there.

When interviewed on 8/9/18, at 10:59 a.m. RN-C stated LPN-B had reported R48 had an open area on the coccyx, was unable to measure the area due to the resident becoming uncooperative though was able to cover the area with a duoderm dressing. RN-C stated she had updated R48's care plan indicating the resident was to be repositioned once awake, before and after meals, for the 3:00 p.m. activity in the afternoon, and at HS (bedtime). RN-C confirmed that would be approximately every 2 hours, as R48 allowed. RN-C stated in the morning staff usually wait until R48 has his eyes open and is ready to get up before initiating cares. RN-C further stated staff do not push it and if R48 was resistive, they let him sleep. RN-C also stated they'd be implementing R48's pressure reducing cushion to be utilized when the resident was in the recliner as well as the w/c. RN-C stated prior to this a pressure reducing cushion had not been utilized in R48's recliner as they had not thought it necessary as the recliner cushion was soft. RN-C confirmed the pressure reducing cushion

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F 686	Continued From page 55	F 686		

should have been utilized in R48's recliner last night and was not sure why it was not. RN-C further confirmed a new dressing should have been applied when R48's previous dressing had fallen off. RN-C stated staff should be monitoring for when the pressure reducing air cushions were deflating and/or needed more air. RN-C stated LPN-A was usually the one to do this as he also worked as a restorative therapy nurse.

When interviewed on 8/9/18, at 1:48 p.m. LPN-A confirmed R48's pressure reducing waffle air cushion was on the low side and definitely needed more air in it. LPN-A stated it was nursing's responsibility to monitor the cushions and make sure they were inflated adequately. LPN-A also stated when the next shift came on at 2:30 p.m. he would have them take the cushion down to therapy to be inflated and would also have staff pick up an extra cushion to keep in the resident's recliner.

Review of the Wound Data Collection dated 8/9/18 by LPN-A identified R48's open areas on the coccyx as moisture associated wounds. When interviewed on 8/10/18, at approximately 10:00 a.m. RN-C confirmed she had not yet visualized R48's open areas on the coccyx and could not say for sure if they were moisture associated or pressure wounds. RN-C further confirmed an RN had not assessed R48's open areas.

During observation on 8/10/18, at 10:38 a.m. RN-C and the director of nursing (DON) confirmed R48 had two stage 2 pressure ulcers on his coccyx and a small 0.5 cm open area on the inner right buttock.

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F 686	Continued From page 56 When interviewed on 8/10/18, at 10:54 a.m. the DON provided documentation of the process staff were to follow when a new skin issue was discovered. The DON stated she would expect staff to notify the RN case manager right away and to fax the physician of the skin issue. The DON stated the RN case manager should evaluate the area as soon as she could to assess and to provide the appropriate treatment and interventions. When the DON reviewed R48's Mobilization Support Data Collection Tool dated 6/28/18, she stated the tool did not fully apply to R48 as he did not sleep in bed and was on his seat much of the time therefore should have been looked at a little differently in terms of positioning. The DON also confirmed a Positioning Assessment and Evaluation had not been completed for R48 to determine an individualized repositioning schedule, and added when R48 stopped utilizing his bed, the care plan should have been updated, and she would have expected a pressure reducing cushion to be utilized in the recliner. The DON stated with repositioning, she would need to see how well R48 slept and what that pattern looked like and go from there. She stated she would've started with every hour and a half to 2 hours for a repositioning schedule. As far as how often to reposition at night if the resident was sleeping would depend upon if he had a good cushion and had pressure mapping completed by physical therapy but confirmed that had not yet been completed for R42. DON confirmed staff should be monitoring for the appropriate amount of air in the cushion R48 was utilizing. DON confirmed an RN should have completed an assessment on the wound when first identified. DON stated when there are new interventions for residents' it will go on the care plan and it will come out with a	F 686		

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F 686	Continued From page 57 "k" and that will transfer to the kardex so the NA's can see them on the kiosk - there was also a 24 communication written at the station for staff as well. DON stated the NA's should have known to utilize the cushion in his recliner once implemented into the care plan. The procedure titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements revised 4/16 included: 6. Residents who are unable to reposition themselves independently, as indicated on the Mobilization Support Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning schedule. 7. If a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA (i.e., for a pressure ulcer, record the stage). The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection UDA. Skin tears and bruises are not intended to be recorded on this form.	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		9/19/18

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F 698	Continued From page 58 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to obtain a written contract between the dialysis provider and the facility for 1 of 1 residents (R20) reviewed for dialysis. This had the potential to affect all residents who received dialysis treatments and resided at the facility. Findings include: R20's face sheet dated 8/10/18, identified an admission date of 2/22/18. The face sheet included diagnoses of end stage renal disease and dependence on renal dialysis. R20's quarterly Minimum Data Set (MDS) dated 5/25/18, identified R20 received dialysis. Review of R20's physician orders dated 8/10/18, included an order for dialysis Monday, Wednesday, and Friday; Medivan pickup at 6:00 a.m. R20's care plan last revised 6/8/18, included dialysis care. On 8/10/18, at 10:56 a.m. the administrator stated the facility did not have a contract or current written agreement with the dialysis facility for coordination of services. The administrator stated she did not know a contract was needed,	F 698	It is the current policy and procedure of GSS-Windom to provide coordination of dialysis care. R20 passed away. No other residents receive dialysis services. If a new client comes on dialysis services from a different clinic than our contracted one, we will initiate a contract with that clinic as well. On Aug 13, 2018, the administrator sent a contract to the dialysis clinic and is awaiting review of the contract by the clinic. This will assure coordination of care for future residents on dialysis services. When the contract is received, the QAPI committee will be notified. If appropriate, the contract auto-renews after 1 year. The QAPI committee will review the contract in August 2019.	

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F 698	Continued From page 59 as there was no billing involved and R20 had been admitted to the facility already going there for dialysis. The administrator stated the facility had residents in the past who required dialysis treatments but it had been several years. The Dialysis Services policy revised 1/18, identified locations caring for residents receiving dialysis services must have an agreement in place with the provider of the service.	F 698		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		9/19/18

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F 725	Continued From page 60 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 provide sufficient nursing staff to provide and meet assessed needs for 1 of 4 residents (R48) reviewed for pressure ulcers, , 1 of 1 resident (R41) reviewed for hospice, 1 of 5 residents (R16) reviewed for accidents, 1 of 1 resident (R7) reviewed for edema, 3 of 3 residents (R4, R48, R54) reviewed for activities of daily living (ADLs), and 1 of 1 resident (R39) reviewed for position mobility. In addition, 3 of 3 residents (R16, R39, R58), 1 of 3 family members (FM-G), and 6 of 6 staff members (RN-C, LPN-A, TMA-A, NA-D, NA-H, NA-I) voiced concerns with the lack of sufficient nursing staff in the facility. The lack of sufficient nursing staff had the potential to affect all 70 residents in the facility along with visitors and staff. Findings include: Pressure Ulcers: R48 was not comprehensively assessed and pressure relieving interventions were not implemented. On 8/8/18, R48 was continuously observed from 7:15 a.m. until 9:38 a.m. lying in a recliner in the dining area. Staff were assisting other residents in and out of the dining room and providing breakfast during that time. R48 had one leg on the footrest of the recliner with the other leg hanging down with one shoe off and one shoe on. R48 would move his legs periodically and would make moaning/humming type sounds.	F 725	It is the current policy and procedure of GSS-Windom to provide sufficient nursing staff to assure resident safety and to attain the highest practical physical, mental and psychosocial well-being of each resident. R48 (FM-G) has passed away. The hospice staffing coordination of R41's hospice care has been reviewed and updated with the hospice company. R16's pain management regime has been reviewed and updated. R7's edema treatment monitoring program has been reviewed and updated as needed. R4, R48, and R54's ADL needs were reviewed regarding assistance and updated as necessary. R39's restorative program was reviewed and updated as necessary. R58, R39, and R16 will receive a 72-hour bowel and bladder assessment, which will be reviewed and used to update the care plan by Sept. 19, 2018. The staffing duties and patterns on the 500-wing have been analyzed and re-organized to better meet the resident needs. All other residents are at potential risk for this deficient practice. A random audit of residents will be conducted by Sept. 19, 2018, to determine if residents on the 200-wing and 400-wing feel there is sufficient staff to meet the care and services they need. If trends or patterns of concerns are found, further staffing patterns and duties will be analyzed.	

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F 725	Continued From page 61 At 9:38 a.m., nursing assistant (NA)-D approached R48 and asked if he was ready to get up; the resident responded he was. NA-D and NA-F pivot transferred R48 into his wheelchair (w/c) which had a pressure reducing waffle air cushion on the seat. The resident's recliner did not have a pressure reducing cushion on the seat. NA-D then propelled R48 into the tub room to be toileted. NA-D indicated the night aide (NA-J) had already completed R48's morning cares earlier when assisted with toileting around 6:00 a.m. (approximately 3 1/2 hours earlier). NA-D and NA-F transferred R48 onto the toilet. Once R48 was finished with toileting, NA-D and NA-F stood the resident up to provide peri-care. R48's bottom was observed to have 2 small open red areas, one on the coccyx and one on the right upper buttock near the crease; the areas were circular and approximately 0.5 centimeters (cm) in diameter. When asked if the areas were new, NA-D indicated they were new to her. NA's then sat the resident back down onto the toilet and alerted the nurse to come into the tub room to observe the resident's bottom. Licensed practical nurse (LPN)-B entered the tub room and confirmed R48 had 2 open areas on his bottom. LPN-B stated the areas were new to her but would have to research the resident's medical record to make sure they had not been there prior to today. LPN-B then instructed the NA's to feed the resident breakfast first prior to providing treatment or measuring the open areas. When interviewed immediately following the observation, NA-D confirmed R48 always slept in the recliner in the dining area. NA-D stated when the resident first came to the facility they would attempt to have him sleep in the recliner in his room as the resident slept in a recliner at home. R48 would crawl out of the recliner in his room	F 725	On Sept.11-14, 2018, all nursing staff will be educated by the Director of Nursing Services and Administrator on the new staffing patterns and duties. On Sept. 17, 2018, all other staff will be educated by the Administrator and Management Team on the new staffing patterns and duties. Sept. 1-Oct. 26, 2018, a total of 30 random audits will be completed by the QAPI Director or designee, asking residents and families if there is sufficient staff to provide the care and services they need. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 725	Continued From page 62 and come out to the recliner in the dining area to sleep. Per R48's preference, they continued to have him sleep in the recliner in the dining area. When interviewed on 8/8/18, at 10:27 a.m. NA-D stated staff try to reposition R48 every 2 hours though sometimes it can be longer. NA-D further stated sometimes the resident was resistive to being reposition and other days he was up and on the move. Fax to physician dated 8/8/18, and sent at 11:34 a.m. indicated: Has an open area on his coccyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or soiled. Fax was returned to the facility 8/9/18 at 10:07 a.m. with physician approval of the order. On 8/8/18, at 1:10 p.m. R48 was observed laying in recliner in the dining room with knees bent and eyes closed. When interviewed at that time NA-D confirmed the resident was transferred into the recliner at approximately 12:50 p.m. NA-D further confirmed LPN-B had not yet measured or done any type of treatment to the open areas on R48's bottom as was awaiting direction from the registered nurse case manager (RN)-C. When interviewed on 8/8/18, at 1:57 p.m. LPN-B stated she had applied a hydrocolloid dressing to the open area on R48's coccyx. LPN-B stated the dressing was large enough to cover the smaller superficial reddish areas below the coccyx as well. When asked about the other open area on R48's right upper buttock, LPN-B stated not realizing the resident had more than one open area. LPN-B then stated she would be back to work tomorrow morning and could look at	F 725		

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F 725	Continued From page 63 it then. LPN-B confirmed she had not measured the open area on R48's coccyx as staff was having a difficult time keeping the resident standing during the treatment. LPN-B stated the open area on the coccyx was approximately 0.5 cm round in diameter. LPN-B confirmed R48 had never utilized a pressure reducing cushion when in the recliner. On 8/9/18, at 8:56 a.m. NA-H and NA-D were observed getting R48 up out of his recliner to perform morning cares. The NA's utilized a standing lift to transfer R48 into his w/c. R48's w/c had a pressure reducing waffle air cushion on the seat with very little air in the cushion; the recliner did not have a pressure reducing cushion on the seat. R48 was then propelled into the tub room to be toileted and assisted with cares. NA's utilized the standing lift to transfer the resident onto the toilet, NA-H removed R48's brief, which was soiled with bowel movement. NA-D asked NA-H if there was a duoderm dressing on the resident's bottom and NA-H informed her there was not. After assisting R48 with washing up and changing clothes for the day, NA-D and NA-H then raised the resident up to a standing position with the lift and provided peri-care. R48 hollered out "Ow!" while his bottom was being cleansed. R48's bottom was observed; there was no dressing covering the resident's coccyx. R48 had two open areas on the coccyx, the upper open area on the coccyx was new since the observation on 8/8/18. The lower open area on the coccyx was larger with white slough covering the wound bed. The area on the right upper buttock near the crease had decreased in size, was reddened and appeared to be closed, there was another small reddened area next to it. NA's put the call light on to alert the nurse. LPN-A	F 725		

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entered the room and measured the open area's on R48's coccyx. The new upper area on the coccyx measured 1.0 cm and was circular, the lower open area measured 1.8 cm x (by) 1.0 cm. LPN-A also identified the small reddened areas on R48's right buttock though felt they were scratches. LPN-A applied skin prep to R48's coccyx then covered the open areas with a hydrocolloid dressing. NA-H then finished dressing R48 and transported him to the dining room for breakfast.

When interviewed on 8/9/18, at 10:49 a.m. NA-E stated R48 was to be repositioned every 2 hours just like all the other residents on the unit.

When interviewed on 8/9/18, at 10:55 a.m. LPN-A stated he was told when coming on duty today that RN-C wanted him to take a good look at R48's bottom as it had been reported there was an open area. LPN-A stated other than that there were no new interventions as was to inform RN-C of what he observed and then she would take it from there.

When interviewed on 8/9/18, at 10:59 a.m. RN-C stated LPN-B had reported R48 had an open area on the coccyx, was unable to measure the area due to the resident becoming uncooperative though was able to cover the area with a duoderm dressing. RN-C stated she had updated R48's care plan indicating the resident was to be repositioned once awake, before and after meals, for the 3:00 p.m. activity in the afternoon, and at HS (bedtime). RN-C confirmed approximately every 2 hours as R48 allowed. RN-C stated in the morning staff usually wait until R48 had his eyes open and was ready to get up. RN-C further stated staff do not push it and if R48

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was resistive, they let him sleep. RN-C stated also implementing R48's pressure reducing cushion to be utilized when the resident was in the recliner as well as the w/c. RN-C stated prior to this a pressure reducing cushion had not been utilized in R48's recliner as did not think it necessary as the recliner cushion was soft. RN-C confirmed the pressure reducing cushion should have been utilized in R48's recliner last night and was not sure why it was not. RN-C further confirmed R48's dressing should have been replaced when the old fell off and that staff should be monitoring when the pressure reducing air cushions were deflating and needed more air. RN-C stated LPN-A was usually the one to do this as he also worked as a restorative therapy nurse.

When interviewed on 8/9/18, at 1:48 p.m. LPN-A confirmed R48's pressure reducing waffle air cushion was on the low side and definitely needed more air in it. LPN-A stated it was nursing's responsibility to monitor the cushions and make sure they were inflated adequately. LPN stated when the next shift came on at 2:30 p.m. he would have them take the cushion down to therapy to be inflated and to pick up an extra cushion to keep in the resident's recliner.

Review of the Wound Data Collection dated 8/9/18 by LPN-A identified R48's open areas on the coccyx as moisture associated wounds. When interviewed on 8/10/18, at approximately 10:00 a.m. RN-C confirmed she had not yet visualized R48's open areas on the coccyx and could not say for sure if they were moisture associated or pressure wounds. RN-C further confirmed an RN had not assessed R48's open areas.

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During observation on 8/10/18, at 10:38 a.m. RN-C and the director of nursing (DON) confirmed R48 had two stage 2 pressure ulcers on his coccyx and a small 0.5 cm open area on the inner right buttock.

When interviewed on 8/10/18, at 10:54 a.m. the DON provided documentation of the process staff were to follow when a new skin issue was discovered. DON stated she would expect staff to notify the RN case manager right away and to fax the physician of the skin issue. DON stated the RN case manager should evaluate the area as soon as she could to assess and to provide the appropriate treatment and interventions. DON reviewed R48's Mobilization Support Data Collection Tool dated 6/28/18. DON stated much of the tool did not apply to R48 as he did not sleep in bed and was on his seat much of the time therefore should have been looked at a little differently in terms of positioning. DON confirmed a Positioning Assessment and Evaluation had not been completed for R48 to determine an individualized repositioning schedule. DON confirmed when R48 no longer utilized his bed the care plan should have been updated and would have expected a pressure reducing cushion to be utilized in the recliner. DON stated with repositioning would need to see how well R48 slept and what that pattern looked like and go from there, though would start with every hour and a half to 2 hours repositioning. As far as how often to reposition at night if the resident was sleeping would depend upon if he had a good cushion and had pressure mapping completed by physical therapy. DON confirmed that had not been completed for R42. DON confirmed staff should be monitoring for the appropriate amount of air in the cushion R48 was

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F 725	Continued From page 67 utilizing. DON confirmed an RN should have completed an assessment on the wound when first identified. DON stated when there are new interventions for residents' it will go on the care plan and it will come out with a "k" and that will transfer to the kardex so the NA's can see them on the kiosk - there was also a 24 communication written at the station for staff as well. DON stated the NA's should have known to utilize the cushion in his recliner once implemented into the care plan. SEE F686 FOR ADDITIONAL INFORMATION Pain Management R16 was not provided care and services in a timely manner to treat an injury resulting from a fall that resulted in a fractured ankle. Review of incident report dated 6/16/18, at 5:40 a.m. identified staff went into R16's room after knocking since resident did not put on call light at 5:30 a.m. as per usual. R16 was found sitting on the floor next to the bathroom door frame. Walker next to her. R16 stated she didn't know what happened. Left foot tender to touch, no more swollen than other ankle. R16 not able to bear any weight after assessing ankle, no bruising, able to move ankle back and forth, up and down. Review of incident report dated 6/16/18, at 7:25 a.m. identified resident was taken to the bathroom as she had her call light on. Staff wheeled R16 into the bathroom. R16 used the grab bar to stand up. Staff moved the wheelchair out of the room so to help resident. Resident suddenly let self slip to the floor. The fall was witnessed. The report also identified the root	F 725		

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cause of the fall may have been that R16's left foot was hurting since she had fallen 2 hours earlier. R16 was assisted with the mechanical lift and 2 staff onto bed. Pain rating was identified as 2.

Review of nursing notes are as follows:
6/16/18, 7:36 a.m. Urine specimen was obtained and sent to WAH (local hospital) for U/A (urine analysis) per Dr's order. Urine is cloudy and amber, foul smell.

6/16/18, 7:48 a.m. Ice pack for swelling to left ankle, every 4 hours as needed apply to left ankle for swelling. Having pain in left ankle.

6/16/18, 8:09 a.m. Resident fell twice within 2 hours. Alert but confused, states "I laid there since 10 p.m. last night". She was in bed at 3:30 a.m. as was checked by this writer (staff). There were no screams coming from room as evidence that there was no obvious way she sat there all night. No tears, flat affect, and skin had no reddened areas of pressure. Left ankle was still painful after administration of PRN Tylenol 650 mg. Called primary doctor since she is confused, urine is very foul and incontinent of urine times 2 in last two hours. Used mechanical lift both times to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks.

6/16/18, 8:13 a.m. After second fall in 2 hours, phoned Dr. to inform she had fallen twice, hurt left ankle, no swelling after 2 hours of initial fall and urine has a foul odor. New orders received (orders were for UA to be done).

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6/16/18, 8:15 a.m. Applied ice pack to left outer ankle and was brought to dining room for breakfast. Has no complaints of pain while addresses tablemate's at breakfast.
6/16/18, 9:06 a.m. Ice pack for swelling to left ankle every 4 hours as needed. Apply to left ankle for swelling PRN (as needed) administration was effective not swollen but still hurts.
6/16/18, 11:02 a.m. Received phone call from Dr. regarding UA, ordered Cipro, after resident was given one dose it was noted that she had an allergy, call MD informed him she had allergy to medication. He stated no concern and it shouldn't be a problem, just watch her. MD then changed to Macrobid 100 mg twice daily for 7 days.
6/17/18, 12:02 a.m. Due to not able to bear full weight on left ankle after her fall, now using sit to stand times two assist to use bedside commode. Left ankle not swollen but is painful. Applied ice pack to affected area. Call placed to eLTC (electronic long term care Dr. available via video) for an order to medicate with PRN Tylenol.
6/17/18, 12:04 a.m. Acetaminophen tablet 650 mg give by mouth every 4 hours as needed for pain. Acetaminophen not to exceed 3,000 mg per day. Contact provider/practioner if fever is present. Discomfort in left ankle, rates 5 out of 10 pain.
6/17/18, 12:07 a.m. Ice pack for swelling to left ankle, every 4 hours as needed. Has ice pack to left ankle, not swollen but is very tender to touch.

6/17/18, 12:14 a.m. Phoned eLTC in regards to pain in left ankle. Change of condition after her falls 6/16/18. Spoke with (eLTC staff) about no pain med in orders. Will receive orders via fax.

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F 725	Continued From page 70 6/17/18, 1:23 a.m. Acetaminophen was given and effective. Follow up pain score 5. 6/17/18, 2:32 a.m. Ice pack for swelling to left ankle. 6/17/18, 3:29 a.m. Resident was sitting up on edge of bed as writer (staff) went by. Asked resident to rate her pain, stated it's better now, said feels better than yesterday. Able to bear full weight on affected left foot. Transferred with sit to stand to bathroom . 6/17/18, Acetaminophen 650 mg given for general aches. 6/17/18, 5:33 a. m. Ice pack for swelling to left ankle. Rates the pain in left ankle as 8 out of 10. 6/17/18, 6;05 a.m. Ice pack for swelling. Stated it feels the same. 6/17/18, 7:00 a.m. Acetaminophen 650 mg administration was ineffective pain scale was a 5 "no help at all." 6/17/18, 4:15 p.m. Resident stated I don't think I can stand on my left leg. When transferred with sit to stand lift put most of weight on that leg with no facial grimace or complaints. Denied pain stated it's a little sore. 6/17/18, 9:57 p.m. Resident stated right ankle hurt. Noted a purple bruise on inner right ankle. Will continue to monitor. 6/18/18, 2:03 a.m. Acetaminophen 650 mg given. Up to bathroom able to bear weight on both legs but stated "very painful."	F 725		

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6/18/18, 2:12 a.m. Ice pack applied to both ankles.

6/18/18 2:16 a.m. Stated "i hurt my right ankle and can't stand on my leg". When placed in sit to stand lift for transfer placed most of weight on that leg with no facial grimace or complaints. Has discoloration of the inner right foot. Stated its a little sore scant swelling bilateral feet.

6/18/18, 2:48 a.m. Ice pack for swelling to left ankle. Took the patchiness away.

6/18/18, 6:58 a.m. Acetaminophen 650 mg given. Pain scale 9. Resident stated no relief to right leg and ankle pain.

6/18/18, 7:30 a.m. Resident complained of severe right leg pain, requesting analgesics.

6/18/18, 8:29 a.m. Pain scale 10. Resident stated no relief from pain.

6/18/18, 11:57 a.m. Acetaminophen 650 mg given. Resident complained of severe right leg and ankle pain.

6/18/18, 1:36 p.m. Acetaminophen 650 mg PRN administration was ineffective. Pain scale 10 resident stated not having any relief.

6/18/18, 8:03 p.m. Acetaminophen 650 mg given.

6/18/18, 11:06 p.m. Acetaminophen 650 mg follow up. ineffective pain scale 5 still hurting badly
.
6/19/18, 12:03 a.m. Very painful when assessing

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right foot which now is bruised entirely around the ankle and top of foot is swollen more than last two days. Rather than bear weight on it will use bed pan tonight. Will get X-ray tomorrow.

6/19/18, 5:09 a.m. Has been using the bed pan to void tonight since she is having so much pain in both feet. Now total lift of mechanical lift with 2 assist to raise up off the bed to change soiled chux. Resident will not turn, insists she's in too much pain to move. Medicated with PRN Tylenol (Acetaminophen) 650 mg for severe discomfort.

6/19/18, 5:10 a.m. Pain is so extreme that the resident needs to be raised in bed using mechanical lift. Noted a bruise on under side of left breast.

6/19/18, 6:39 a.m. Has a whirlpool bath. Two assist out of bed with sit to stand lift. Right foot is swollen +2 and bruised Did have a lot of pain when transferred from bed to wheelchair.

6/19/18, 6:39 a.m. Acetaminophen 650 mg was ineffective. Pain scale 8. Resident continues to rate pain severe.

6/19/18, 9:17 a.m. faxed MD questioning if needs x-ray right foot related to swelling, bruising and pain following fall of 6/16/18.

6/19/18, 2:41 p. m. Fax received from MD that may obtain x-ray of right foot/ankle.

6/19/18, Called family member and informed of x-ray of right foot/ankle scheduled at hospital for 6/20/18 at 11:00 a.m.

6/19/18, 8:10 p.m. Acetaminophen 650 mg given

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for ankle pain.

6/20/18, 12:19 a.m. Asleep at this time.

6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain.

6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief.

6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair.

6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resdient complained of moderate pain in right ankle. Requesting analgesics.

6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5.

6/20/18, 4:30 p.m. Discussed pain with residnet and stated not so bad mostly hurts when I lie down and put covers on it. Stated splint supports it and is more comfortable.

6/20/18, 8:18 p.m. Acetaminophen 650 mg given for pain scale of 4.

6/21/18, 3:10 a.m. Acetaminophen 650 mg given.

6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8.

6/21/18, 8:15 a.m. TO hospital for surgery right ankle.

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6/21/18, 7:05 p.m. Returned from hospital where she had right ankle repair about 6:30 p.m. She is in a wheelchair. Right foot is splinted and wrapped with ace. Rates pain at 8 of 10. Will medicate when meds arrive.

6/21/18, 8:30 p.m. Given Ketorolac 10 mg for pain level of 8.

An order from eLTC dated 6/17/18, at 1:00 a.m. identified nurse called requesting order for Tylenol for pain. Patient recently sprained her left ankle, had an order for ice but no order for pain medication. At this time Acetaminophen 325 mg two tablets every 4 hours PRN pain was ordered.

A fax was sent to the MD on 6/16/18, at 5:40 a.m. The fax identified R16 was found on the floor walking to the bathroom with 4 wheeled walker. ROM (range of motion) to left ankle painful when putting pressure on foot, no swelling. Does not want to stand on left ankle. No bruising. The fax was faxed back to the facility on 6/18/18, at 12:20 p.m. with physician comment, "I was called about this, I assume all is now well. Yes? The fax was noted as received back at facility 6/18/18. No reply was sent to the physician regarding pain and swelling of right ankle.

Review of the x-ray results dated 6/20/18, identified a Weber type B distal fibular/lateral malleolar fracture or the right ankle.

Review of pain assessment dated 6/18/18, identified pain associated with a diagnosis or condition, non-pharmacological interventions of ice and rest. The assessment also identified the current medication regime of PRN Tylenol 650

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F 725	Continued From page 75 mg and ice PRN was not working. During interview with the director of nursing (DON) on 8/9/18, at 10:24 a.m. she stated staff should have been in touch with the Dr. in a more timely way than faxing. She verified no follow up was done as far as pain medication not being effective, pain status, change in condition and what was being done to treat her. She stated with complaints of pain something obviously changed since there was swelling and bruising. She stated R16 was independent in her room with walking prior to the falls but after the falls she needed to be transferred with mechanical lift and 2 assist. She stated the MD should have been called back on 6/18/18, when we received the fax back and told about the increased pain and swelling and change in condition. She stated when they faxed on the 19th about an x-ray they should have called and not faxed the Dr. to get her in for an x-ray that day. She stated they saw bruising on the 17th, first on the left then on the right which should have been addressed. She stated we have pain meds in the e kit we could have used to make her more comfortable since the Tylenol was obviously not working for pain control. During interview with the attending physician on 8/14/18, at 3:22 p.m. he stated he should have been notified of the increased pain and swelling of the ankle. He stated he was notified of the fall the morning it happened. He stated he did not see the fax from the 16 until Monday morning the 18th. At that time he stated I responded back and asked if everything was ok. He stated I did not hear anything back from them until they asked for an x-ray on the 19th.	F 725		

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F 725	Continued From page 76 Review of the policy Notification of Change dated 11/2016, indicates the facility must immediately consult with the residents physician when there is a significant change in the residents physical, mental or psychosocial status and a need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. Hospice Coordination: The facility failed to coordinate hospice services for R41. R41's medical director certification/recertification dated 6/7/18, identified a hospice start of care date of 3/18/18, with diagnosis of senile degeneration of the brain. R41's significant change MDS dated 3/23/18, identified R41 had a severely impaired cognition and total dependence in all activities of daily living. The MDS also identified R41 was receiving hospice services. R41's care plan revised 4/3/18, identified R41 had a terminal prognosis related to end stage dementia and was receiving hospice care. Interventions included, assess resident and family coping skills, contact hospice staff for support as needed, work with nursing staff to provide maximum comfort for the resident. At the nurses stations on a clip board under numerous papers was a paper that said attention facility staff! R41 is under the care of (name of hospice). The team was identified as nurse, social worker and chaplain. No aide or volunteer was identified. Another paper was under the first on that said (name of hospice) nurse-weekly visits on Monday, Aide- provides AM ADL cares	F 725		

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Monday thru Friday. Chaplain/SS (social service) Thurs/Fri. No patient name is identified on this paper nor are times . The hospice agency plan of care provided by the facility did not have any a visit schedule on it.

During observation on 8/8/18, at 7:05 a.m. hospice aide was present giving R41 a bath. At 7:43 a.m. R41 was sitting at the breakfast table being fed by a staff member. Hospice aide left after giving R41 her bath.

During observation on 8/9/18, at 7:47 a.m. hospice aide was present feeding R41.

During interview on 8/8/18, at 8:13 a.m. nursing assistant (NA)-D stated we don't know what they are going to do when they come. For instance today they couldn't feed her because they had to go do something else. Sometimes they give her a bath and feed her, sometimes they just feed her. We never know. We don't know days or times they come either. Sometimes they tell us sometimes they don't. I think they are supposed to come 3 days a week or something but they maybe only come two. We never know what time. sometimes it's 6 a.m. when they are supposed to be her at 8, we never know. They have come at like 4 in the afternoon before too.

During interview on 8/8/18, at 8:30 a.m. NA-F stated you never know around here when they will come. Sometimes they come and then they have to leave because they have to go somewhere else so they don't do everything they are supposed to. If they can't make it they don't tell us they just come another day.

During interview on 8/8/18, at 9:00 a.m. RN-C

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stated well there is a calendar at the desk. The aide comes every morning Monday through Friday between 6 and 8 a.m. they have a chaplain and a social worker that come later part of the week. The nurse comes on Tuesday, she was here yesterday. She has a volunteer that comes a lot. If they can't make it they don't tell us they just come another day. My hospice people are stable so I'm not concerned about it. If they do let the nurse know they aren't coming then the aides should be told that too.

During interview on 8/8/18 at 9:28 a.m. licensed practical nurse (LPN)-B stated she did not know where the calendar for hospice was located to know when they came. RN-B came onto unit and stated the calendar is under the clip board.

During interview on 8/09/18, at 7:47 a.m. hospice aide (HA)-A stated we are here 5 days per week for R41. She stated I come at 5:30 because I have another patient here. We have 5 different aides and we all have different schedules. It depends on where the clients are and who has them as to when they come. If I do morning cares then I don't feed and if I don't do morning care then I feed her breakfast, play music, curl her hair. Normally her bath is done so then I feed her. Yesterday I had to go because we were short someone called in so we had to split visits up so I had to go. She stated I don't talk to the staff really unless something out of the ordinary. I just come in and go to her room and help her. If I need to tell them something I will, like if something is different or out of the ordinary.
During interview on 8/9/18, at 12:47 p.m. she stated the hospice should give us a schedule. We need to tell them we don't know when their people are coming. That is not good

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communication for continuity of care.

Edema Monitoring:

The facility failed to monitor edema (fluid retention) R7 with edema in feet/ankles. R7's diagnosis report dated 8/10/18, included diagnoses of edema, macular degeneration (an eye disease that causes vision loss), and dementia.

Review of R7's current physican orders dated 6/12/18, included Lasix (a medication to reduce extra fluid in the body) 80 milligram (MG) daily for edema.

During observation on 8/8/18, at 12:50 p.m., R7 was observed to have bilateral edema in her feet and ankles. The resident was sitting in a recliner chair in her room with her feet resting on the floor. The resident had velcro closing shoes and grippy socks on, however there was visible indentation to R7's ankles from the grippy socks. The right ankle also had a reddened appearance.

During observation on 8/9/18, at 8:46 a.m. nursing assistant (NA)-C transferred R7 into a recliner chair. R7 was wearing socks and shoes, however visible bilateral edema to ankles was noted, and her feet remained on the floor when NA-C left the room.

During interview on 8/8/18, at 10:04 a.m. NA-C confirmed R7 had edematous ankles. NA-C further stated there were no specific interventions for the edema but indicated R7 would elevate her feet if she wanted to.

During interview on 8/8/18, at 1:09 p.m.

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registered nurse (RN)-B indicated R7 had long standing edema to her lower extremities. RN-B confirmed there was no formal monitoring in place for the edema.

During observation and interview on 8/9/18, at 2:22 p.m., R7 was sitting in her recliner chair with her feet on the ground. RN-C assessed R7's lower extremities stating they were cool and dry. RN-C further verified right lower extremity had a redness present but no warmth or discomfort noted from R7. RN-C identified R7 had two plus pitting edema (swelling that is significant enough to cause an indentation of 3-4 millimeters deep in the skin when depressed with a finger) in right ankle and foot and one plus pitting edema (indentation of 2 millimeters) in left ankle and foot. RN-C stated R7 had refused to wear support stockings in the past, however indicated R7 should have other interventions in place to manage and monitor the edema, confirming there was nothing in place at this time.

During interview on 8/10/18, at 2:48 p.m. the director of nursing (DON) confirmed R7's lower extremity edema should be monitored with interventions in place to control it.

SEE F684 FOR ADDITIONAL INFORMATION

Activities of Daily Living (ADL's):

R4 was not given assistance with nail care and shaving. R4's care plan reviewed 8/7/18 indicated the resident required assistance of 1 staff with personal hygiene. The care plan further identified interventions to use if R4 was exhibiting behaviors during cares.

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During observation on 8/6/18, at 1:56 p.m. R4 was noted to have long soiled fingernails and long white hair on her chin.

During observation of morning cares on 8/8/18, at 7:16 a.m., R4 continued to have long nails and chin hair. Nursing assistant (NA)-D looked at R4's long dirty fingernails and stated "oh I wish you'd let us trim your nails". Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no attempt to trim nails, shave chin hair or provide oral care.

During observation on 8/08/18, at 2:43 p.m. R4 was observed in the dining room feeding herself an apple turnover with long dirty nails and long white chin hair.

During observation of morning cares on 8/9/18, at 10:19 a.m., R4 continued to have long nails and chin hair. NA-E stated R4 was in a "wonderful mood" and it was a good time to complete cares. Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no offer of shaving, oral cares or nail care.

During interview on 8/9/18, at 1:23 p.m. NA-D and NA-E confirmed they had not offered oral care, shaving, or nail trimming to R4 with morning cares. NA-D further indicated R4 required assistance with these grooming tasks and confirmed R4 had long fingernails and chin hair.

During interview on 8/9/18, at 2:09 p.m. registered nurse (RN)-C confirmed R4 had long fingernails and chin hair which she described as a "goatee". RN-C indicated R4 has behaviors and will refuse cares, however oral care and shaving should be offered daily before breakfast, and

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nails trimmed and cleaned when R4 allows.

On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to shave, trim nails and provide oral cares prior to breakfast. The DON further stated she had gotten R4 a new razor about one week prior and would expect staff to reapproach or complete tasks when she was cooperative if refused.

R54 was not provided assistance with oral care. R54's care plan last revised 7/4/18, identified a self care performance deficit related to left hemiparesis and inability to independently bathe, dress, or groom. The care plan further identified R54 with several natural teeth broken off. Interventions included staff assistance with personal hygiene and assist to brush teeth after set up twice daily.

R54's ADL care area assessment (CAA) dated 11/7/17 indicated extensive to total assist was needed for all ADL's due to hemiplegia.

During interview on 8/6/18, at 7:14 p.m. family member- A stated she frequently notices food between R54's teeth and questioned if his teeth were being brushed twice daily.

On 8/8/18, at 7:38 a.m. R54 was sitting in his room in a Broda chair. He indicated his teeth had not been brushed. An oral care basin, including a dry toothbrush was observed in the medicine cabinet above the sink in R54's room.

On 8/8/18, at 9:43 a.m. R54 was observed to be sleeping in his bed. The oral care basin was observed in the same location with a dry toothbrush.

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On 8/8/18, at 1:19 p.m. toothbrush remained dry.

During interview on 8/8/18, at 1:31 p.m. NA-C stated oral cares are completed when getting residents up in the morning. NA-C then confirmed she had not brushed R54's teeth this morning stating she had "forgot".

On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to provide oral cares per plan of care.

R48 was not provided assistance with oral care and eating. R48's care plan dated 7/7/18, indicated the resident had his own teeth and required extensive assistance of one staff with oral cares. Oral cares to be performed BID (twice a day) as he allows.

When interviewed on 8/6/18, at 4:17 p.m. family member (FM)-G stated feeling R48's mouth had seemed quite dirty at times and wondered if staff brushed his teeth.

On 8/9/18, at 8:56 a.m. nursing assistants (NA)-D and NA-H were observed providing morning cares for R48. NA's transferred R48 from the recliner where he slept in the dining area, into his wheelchair (w/c) via a standing lift. NA-H then propelled R48 into the tub room. NA-H and NA-D then transferred R48 via the standing lift onto the toilet. NA-D donned gloves and assisted the resident with washing his face then cleaned his hands and fingernails thoroughly. NA-D then obtained a clean washcloth and towel and washed and dried R48's underarms. R48 was swishing his mouth as if he had food or liquid in it. NA-D asked R48 if he needed to spit and brought

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F 725	Continued From page 84 a towel up to his mouth but the resident wouldn't spit. NA-D doffed her gloves and obtained toothettes to utilize for oral care but did not provide it. NA-D and NA-H then raised resident up and provided pericare; during that time licensed practical nurse (LPN)-A entered the tub room and completed a treatment to R48's bottom after pericare was completed. Once LPN-A completed the treatment, NA's then finished with dressing R48 and transferred him into his w/c. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care. When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes. Further review of R48's care plan, last revised 7/24/18, indicated the resident required extensive assist of one staff with eating, and to provide the resident with a calm, quiet setting at meal times with adequate eating time. The care plan further indicated R48 holds liquids/food in mouth and needs reminders to swallow. On 8/6/18, at 5:50 p.m. R48 was continuously observed seated in his wheelchair (w/c) at the dining room table in Heritage Court during the supper meal; R48's meal was served at that time. At 6:00 p.m. nursing assistant (NA)-G addressed R48 and asked him if he was going to eat, NA-G was assisting another resident at the same table at that time. NA-G showed R48 that his spoon was on his plate; the resident had his hands wrapped up in his clothing protector at that time.	F 725		

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At 6:05 p.m., licensed practical nurse (LPN)-C approached R48 to administer medications that were mixed in pudding. With assistance from NA-G, LPN-C eventually was able to administer the medications in pudding to the resident as he required verbal prompts and encouragement to swallow the medication as would swish it around in his mouth. The resident was observed to take a drink of his fluids independently but other than the pudding that the medications were mixed in, R48 still had not eaten any of his meal nor offered assistance. The resident continued to drink his fluids independently but would not attempt to eat his food. At 6:28 p.m., NA-K sat next to R48 and assisted the resident with eating his fruit, the resident had already consumed all of his fluids at that time. R48 accepted the offered food and ate approximately 50% of his fruit. At 6:40 p.m., NA-K got up from the table and heated up R48's meal in the microwave then set it on the table in front of R48. NA-K did not offer to assist R48 with eating his meal nor offer more fluids to the resident. At 6:55 p.m., R48 picked up his fork with a bite of potatoes on it, raised it slightly, then set it back down on the plate; R48 was not observed to eat any of his food other than the fruit he had been assisted with.

When interviewed on 8/6/18, at 6:55 p.m. LPN-C stated R48 usually ate good on his own but was not having any of it tonight. LPN-C stated they would check with the resident later to see if he would eat a snack.

On 8/9/18, at 9:49 a.m. R48 was continuously observed during his breakfast meal. LPN-A was observed to prepare and set-up breakfast for R48. LPN-A placed R48's plate in front of him then continued to pass medications in the dining

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F 725	Continued From page 86 room; LPN-A did not offer to assist R48 with eating. At 9:51 a.m., LPN-A asked R48 if he was going to try his breakfast. The resident didn't respond. LPN-A then asked NA-D to assist R48 with eating. NA-D assisted R48 with eating until 10:00 a.m. as went to assist another resident; LPN-A was also administering medications to R48 at that time. LPN-A administered R48's medications in pudding then offered the resident a drink. R48 observed to swish the fluid around in his mouth. When NA-D returned to assist R48, LPN-A instructed NA-D to not attempt to feed R48 more at that time as he wasn't swallowing and didn't want the resident to choke. At 10:17 a.m., R48 was observed to place his glass containing his supplement into his oatmeal; LPN-A continued to administer medications and NA-D and NA-H were assisting other residents. At 10:21, a.m., LPN-A approached R48, removed his glass of supplement from the oatmeal, and attempted to assist the resident with eating. LPN-A offered the resident a drink of orange juice which he accepted. LPN-A prompted R48 to try to swallow the juice rather than swishing it around in his mouth. LPN-A then washed his hands and continued to set-up and administer medications. At 10:26 a.m., R48 was observed with his fingers in his oatmeal; the resident continued to swish has food/fluid contents in his mouth. R48 would spit some of it out at times then wiped his mouth with his fingers. At 10:34 a.m., the pastor entered the dining room and greeted the residents stating they were going to have hymn sing. R48 was observed to take drinks of his Kemps supplement during the activity but did not attempt to feed himself. At 10:49 a.m., NA-E (who had come to replace NA-H on the unit at 10:00 a.m.), approached R48 and cleaned the oatmeal off his hands. NA-E asked the resident if he was	F 725		

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finished eating and the resident indicated he was. NA-E also asked R48 if he wanted to finish his juice and the resident indicated that he did. When interviewed at that time, NA-E confirmed that sometimes R48 was able to eat independently and sometimes required assistance.

When interviewed on 8/9/18, at 10:59 a.m. RN-C confirmed R48 required extensive assistance of one staff with meals though sometimes he did refuse to eat. RN-C stated if the resident was resistive to assistance would expect that staff would stop and then reapproach. On subsequent interview on 8/10/18, at 2:41 p.m. RN-C stated the staff on Heritage Court had a lot of people to feed and not enough help.

SEE F677 FOR MORE INFORMATION

Restorative Nursing:

R48 and R39 did not receive restorative nursing services per the plan of care.

R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to dementia, Parkinsonism evidenced by freezing gait and physical weakness. The care plan interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2-3 times a week.

Review of R48's Documentation Survey Reports dated May 2018-August 2018 related to restorative nursing rehab completion indicated the following: May 2018 - one time out of 23 opportunities (5/18/18). June 2018 - 3 times out

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of 21 opportunities (6/8/18, 6/14/18, 6/19/18). July 3018 - 2 times out of 21 opportunities (7/2/18, 7/31/18). August 2018 - 1 out of 8 opportunities (8/1/18).

When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to

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F 725	Continued From page 89 restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. During interview with R39 on 8/7/18, at 9:22 a.m. she stated, I supposed to get rehab 3 times a week. I get arm and leg exercises and do the step. I am supposed to have exercises on my band hand too. She further stated I haven't had it at all in August yet. In July I had it 4 times. R39 took me to her computer and pulled up a spread sheet she had made. She had documented on the spread sheet the days in July she received restorative. The days were 2, 5, 24 and 31. She stated a staff member had retired on June 30 and since this occurred it has been really bad. She stated one of the nurses was supposed to be doing it and the nurse is not very good. She stated there is one other girl who is very good but I haven't seen her in awhile. She stated I am supposed to get it Monday, Wednesday and Friday. On 8/7/18, at 11:30 a.m. R39 was observed in the therapy room with aide performing restorative exercises. R39 looked at surveyor, shook her head, shrugged her shoulders and smiled. On 8/9/18, at 2:05 p.m. R39 was asked if she got walked by staff. She laughed and pointed to a June calendar on the back of her door and stated well look at that, that will tell you. Staff had initialed on June 13, 14, 15, 17 and 18th that resdient was walked. She said that's how much I got walked. I was supposed to walk 1-2 time a day. Now they don't walk me at all. They just didn't and I don't know why.	F 725		

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F 725	Continued From page 90 When asked if she was able to walk now she stated I was able to before but don't know if I still can. I haven't done it for a lot of days. R39's care plan, last revised 1/5/17, indicated the resident had a need for restorative intervention due to limited physical mobility related to weakness and old CVA (cerebrovascular accident) with right hemiparesis evidenced by inability to independently transfer and ambulate. Goal: resident will maintain current level of mobility of transferring independently in bathroom using handrail. Interventions included active range of motion (ROM) upper extremity (U/E) left with red T-band, 20 repetitions (reps) times 2, 3 times per week, active ROM lower extremity (L/E) left seated exercises with 3# weight 20 reps 3 times per week, active ROM L/E right seated exercises with 0# weights 10 reps 3 times per week, active ROM NuStep at level 5 10 min 3 times per week, passive ROM to right arm 20 reps as tolerated 3 times per week. The care plan updated 8/2/18, also indicated R39 was unable to ambulate or transfer independently using a total lift for transfers. Review of R39's nursing notes does not indicate why resident was not walked or had restorative per the care plan. A note written 8/8/18, (after surveyor identified issue) identified that due to changes in resident condition she is no longer able to ambulate or use the NuStep as part of her restorative program. Once she has stabilized an order for skilled therapy to evaluate and treat will be obtained to set up further orders for her restorative program. Resident is not realistic about her abilities but this has been explained to her.	F 725		

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F 725	Continued From page 91 Review of R39's Documentation Survey Reports dated June 2018-August 2018 related to restorative nursing rehab completion indicated the following: Walking 1-2 times per day: May 2018, 2 times (5//10, 5/29) June 2018, 7 times, (6/4, 6/5, 6/11, 6/15, 6/18, 6/19 and 6/28). July 2018, 2 times (7/3, 7/9). 20 days were marked not applicable. August times 2 (8/1 and 8/2 non applicable rest x' d off). Restorative exercises: July 4 days (7/2, 7/5, 7/24, 7/31) 4 refusals. August times 2 (8/7, 8/8). When interviewed on 8/8/18, at 8:00 a.m. physical therapy aide (PTA)-A stated I know that restorative is short so I don't know how much is getting done I think nursing is doing it if they don't have aides When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day. She stated she gets upper and lower exercises and the NuStep. She stated it depends on who is doing it if she refuses. She has never refused for me. You have to try to get her before bible study because she always goes to that if you get her from 9:15 to 9:30 it's fine. She stated I see her M-Tu-Th if I don't get pulled to the floor. We had someone retire at the end of June so it doesn't always get done. When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.	F 725		

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When interviewed on 08/10/18, at 12:14 p.m. nursing assistant (NA)-L stated R39 walked with 2 assist 20-30 feet. She stated it's been a couple weeks I think. The aides do the walking as well as restorative.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff. PT-H stated R39 had a program a while back and was transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of

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therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative sheets. It should be refused or not available. She stated I don't know why she wasn't walked in July. She stated she just started with a change in condition this week. I don't know why she didn't get it in June. We had someone retire end of June so that could be why it didn't get done July and August.

SEE F676 FOR ADDITIONAL INFORMATION

RESIDENT/FAMILY CONCERNS WITH LACK OF STAFFING

R48's quarterly MDS dated 6/29/18, identified R48 had severe cognitive impairment and required extensive assistance to complete his ADLs. When interviewed on 8/6/18, at 4:07 p.m. family member (FM)-G stated sometimes it takes a while for R48 to get help to get to the bathroom; staff had told her he usually gets there on time prior to being incontinent. FM-G further stated feeling R48's mouth had seemed quite dirty at times and wondered if staff brushed his teeth.

R39's quarterly MDS dated 6/15/18, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further indicated R39 required extensive assistance with toileting. When interviewed on
8/7/18, at 9:15 a.m. R39 stated last night they were short of help. They have to have 4 (NAs) working but a lot of times they don't; we have to wait. R39 further stated having to wait an hour before, and had been incontinent due to waiting so long.

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R16's Quarterly MDS assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. When interviewed on 8/6/18, at 6:44 p.m. R16 stated having to use the bed pan at night because it takes two people to use those machines (lifts) and I had to use the machines. R16 further stated the bed pan would go over and then I would end up with a wet nightgown; they said there is no other way you just have to put up with it.

R58's admission MDS dated 7/9/18, identified a BIMS score of 8 indicating moderate cognitive impairment. The MDS further indicated the resident required extensive assistance with transfer and toilet use. When interviewed on 8/6/18, at 4:01 p.m. R58 stated having to wait up to an hour for assistance with toileting. R58 further stated having had accidents in my pants, "It just happened last night. I was laying in poop for over 20 minutes."

STAFF CONCERNS WITH LACK OF STAFFING

When interviewed on 8/6/18, at 2:34 p.m.trained medication aide (TMA)-A stated they usually staffed Heritage Court with 1 nurse or TMA and 2 NAs. TMA-A stated that was usually a good resident to staff ratio though in the evening when the resident's sundown it can get really wild. TMA stated she had worked an evening shift last week and was really glad she had 2 NA's on as it doesn't always work out that way.

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When interviewed on 8/9/18, at 10:29 a.m. NA-H stated she was supposed to be done at 10:00 a.m. this morning and is just getting ready to leave. NA-H stated they usually have a night aide that stays and helps them get people up but she had to leave for her other job at 6:30 a.m. so they ran behind today. NA-H stated sometimes they could use more help in Heritage Court. NA-H further stated feeling that there should always be a staff person in the main dining room area where most residents gather when out of their rooms; sometimes that isn't possible when the staff need to be in rooms to assist other residents. NA-H then stated, "Yes, we could use more help."

R48 was not provided assistance with eating. When interviewed on 8/9/18, at 10:59 a.m. RN-C confirmed R48 required extensive assistance of one staff with meals though sometimes he did refuse to eat. RN-C stated if the resident was resistive to assistance would expect that staff would stop and then reapproach. On subsequent interview on 8/10/18, at 2:41 p.m. RN-C stated the staff on Heritage Court had a lot of people to feed and not enough help.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A indicated Heritage Court was really no different from any other part of the building as far as staffing. LPN-A stated he floats all over the building and also works in restorative therapy. LPN-A further stated he was pulled from restorative today to work in Heritage Court as the nurse scheduled called in. LPN-A confirmed that when working the day shift on Heritage Court, the TMA or LPN scheduled is responsible for serving the residents their breakfast and further confirmed this did put his medication pass

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behind. LPN-A further confirmed nurses/TMAs on other units are not responsible for serving the breakfast meal. When asked if the restorative services he was to provide that day for residents were still being completed, LPN-A stated he didn't know.

When interviewed on 8/9/18, at 2:13 p.m. NA-D states sometimes they have enough in Heritage Court but not always; a lot of it depended upon how the residents were doing related to health and behaviors. NA-D stated the night staff NA was supposed to stay until 7:30 a.m. to help get residents up but that doesn't always happen. NA-D further stated there are some night staff that refuse to stay until 7:30 a.m. so they only schedule those employees until 6 a.m. NA-D stated today they didn't have a night person stay and it was really difficult to get every one up and fed as the other NA who worked until 10:00 a.m. and was giving baths. NA-D further stated many of the residents are 2 person assist so she had to wait to get assistance with those residents.

When interviewed on 8/10/18, at 10:36 a.m. NA-I stated it depended upon the day but at times it could be very overwhelming in Heritage Court. NA-I stated she usually worked evenings and felt that shift was the worst, especially from 3:00 - 4:30 p.m. as they were many times down to 2 staff during that time. NA-I further stated on the day shift it's very busy when they are getting resident's up in the morning; usually a night shift staff will stay until 7:30 a.m. to help but not always. NA-I stated having one more staff on the unit would definitely help. NA-I also stated they try to always have a staff in the dining area as that is where the majority of the residents gather when awake; occasionally they would leave the

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area with no staff present but it's a very short time.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done.

During interview on 8/10/18, at 3:34 p.m. the human resources (HR) director stated they had an acuity rate which determines the staffing on each unit.

When interviewed on 8/10/18, at 3:42 p.m. the administrator stated the acuity of staff is based on number of residents in the building; where staff was disbursed was based on the acuity of the residents per station. Ideal staffing: Heritage Court- 2 day NAs and one nurse or TMA. Evening the same and nights 1 NA (RN or LPN scheduled at night covers the building). Center - 4 day NAs, 1 nurse, 1 case manager for Center and Heritage Court (400 and 500 wings), Evenings - 4 NAs and a nurse. Nights- 2 NAs.

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F 725	Continued From page 98 South: Days - 4 NAs, 1 nurse and case manager. Evenings - 4 NA's and 1 nurse. Nights - 1 NA and 1 nurse. The HR director confirmed the restorative aide got pulled a lot to the floor, to complete patient cares vs completing restorative nursing tasks.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		9/19/18

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F 755	Continued From page 99 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications stored in 2 of 2 emergency drug kits were not expired, and available for use in an emergent situation. This had potential to affect any of the 78 residents residing in the facility, who may have needed these medications in an emergent situation. Findings include: On 8/9/18, at 2:18 p.m. the central medication room was toured with the director of nursing (DON). A clear plastic tackle-style emergency kit was housed in the refrigerator and inspected. Inside, two unopened vials of lorazepam (an antianxiety medication) 2 milligrams (mg)/milliliter (ml) were found to be available to resident use, however both vials had expired several months prior. Further, another tackle-style kit was removed and inspected from the cabinet which contained two unopened vials of Benadryl (an antihistamine medication) 50 mg / ml. These were also found to be expired. A total four doses of expired medication(s) were identified with the medication storage review. When interviewed immediately following, the DON stated the dispensing pharmacy was responsible to maintain the emergency kits as they take ownership of the medications inside. DON explained she was not sure when these kits were last checked for their expiration dates, and was going to check into it.	F 755	It is the current policy and procedure of GSS-Windom to assure all drugs in the emergency kits are non-expired. The expired medications were removed and replaced on Aug. 9, 2018 by Lewis Drug. All other medication expiration dates were also checked at this time and found to be current. On Sept. 5, 2018, the consulting pharmacist was re-educated on the emergency kits and his role in checking the dates of the drugs. All licensed nursing staff will be re-educated Sept.11-12, 2018 for their role in ensuring medications in the emergency kits are current. The local pharmacist was re-educated on Aug. 14, 2018 regarding his responsibility to ensure the medications are current. An audit of medication expiration dates in the emergency kits will be conducted by the Director of Nursing Services or designee, 1x weekly for 13 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 755	Continued From page 100 An untitled, undated, handwritten statement was provided afterwards which identified the refrigerator emergency kit had not been updated since 4/14/17. No further information was provided to demonstrate when the kit containing the Benadryl had been last reviewed. A provided Procedure for Emergency Drug Boxes policy dated September 2012, identified the emergency kits were provided by the pharmacy and, "The pharmacist is responsible for monitoring expiration dates."	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 812	It is the current policy and procedure of	9/19/18

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F 812 Continued From page 101

review, the facility failed to ensure meal items were heated and served hot enough to reduce or prevent potential foodborne illness. Further, the facility failed to ensure 1 of 1 production mixers was maintained in a clean and sanitary manner; and failed to ensure appropriate storage measures were implemented to prevent potential cross contamination of dried goods stored in non-original containers. These findings had potential to affect all 78 residents residing in the facility at the time of survey.

Findings include:

On 8/7/18, at 11:20 a.m. the lunch meal service was observed. Cook (CK)-A had several items on the steam table to be served to the resident population including taco meat, pork chops, mashed potatoes, sage dressing, kernel corn, tan gravy. In addition, CK-A had pureed carrots, pureed pork chops and mechanical soft texture pork chops and taco meat to be served. CK-A stated these items had just been removed from the oven and placed in the steam table a few moments prior. CK-A had documented temperatures on a flow sheet which identified just the taco meat and pork chops at appropriate temperatures for service. None of the other prepared items had temperatures recorded to demonstrate they had been checked for proper serving temperature to reduce the risk of foodborne illness. CK-A verified only the two meat options had been checked and stated he was going to check the other food items temperature upon return from being away from the kitchen. The surveyor requested a temperature check on the prepared items, and CK-A removed a bayonet-style thermometer from a coffee cup sitting on the counter which

F 812

GSS-Windom to serve meals in accordance with professional standards for food service safety and to provide a clean and sanitary kitchen environment.

The can opener and mixer were cleaned on Aug. 6, 2018. The plastic container and scoop were washed and the powdered sugar disposed of on Aug. 6, 2018. The thermometer was sanitized and re-located to its own container on Aug. 7, 2018. The food temps on Aug. 7 were re-taken on Aug. 7, 2018 and found to be compliant, as the cook had originally taken the temperatures in Celsius instead of Fahrenheit. The cook was immediately re-educated by the dietary supervisor on how to store, sanitize, and read the thermometer.

All other kitchen equipment is at risk for this deficient practice and was audited and followed up on as appropriate by the Dietary Supervisor for cleanliness on Aug. 6, 2018. The kitchen cleaning schedules will be audited and updated as necessary by the Dietician, and the Dietary Supervisor on Sept. 12, 2018.

All dietary staff will be re-educated on cleaning practices and their current cleaning schedules which include these items, on Sept. 12, 2018 by the Dietician and Dietary Supervisor. All cooks will be re-educated on thermometer reading, storage, and sanitizing on Sept. 12, 2018 by the Dietician and Dietary Supervisor.

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F 812	Continued From page 102 contained another thermometer, a scissors and various pens and pencils. CK-A did not sanitize the thermometer before placing it in the prepared food items to be served. CK-A and the surveyor observed the thermometer, and CK-A stated aloud the following temperatures being identified for the various food items: Taco meat - 91 degrees Fahrenheit (F), Pork chop - 94 F, and, Sage dressing - 91 F. CK-A then turned to the surveyor and stated aloud, "What do you want me to do?" The surveyor asked CK-A what his normal process would be to implement if food temperatures were low, however, CK-A responded the residents' would be upset if the meal was too late and he did not want to overcook the food items. He stated he would wait five or 10 minutes with the food in the steam table and then recheck the temperature. Approximately 10 minutes later, CK-A checked the sage dressing and there was no temperature change, so he placed it back in the oven. CK-A did not check or place any of the other food items back into the oven to ensure they were hot enough to serve. At 11:45 a.m. CK-A checked all the food items and identified the following temperatures while they were in the steam table: Taco meat - 91 F, Pork chop - 94 F, Sage dressing - 91 F, Corn - 97 F, Gravy - 81 F and, In addition, all of the pureed and mechanical soft items were <100 F.	F 812	An audit by the QAPI Director or designee will occur of kitchen equipment cleanliness and appropriate food temperatures at serving time, 3x/week for 4 weeks and then weekly x8 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 812	Continued From page 103	F 812		

After obtaining the temperatures, CK-A unplugged the steam table and brought it to the main dining room despite the low temperatures being identified. CK-A then began to plate and serve the food from the steam table.

Dietary manager (DM)-A was alerted to these findings, and stated the food should have been re-heated to ensure a safe serving temperature. DM-A acknowledged the residents' would likely become upset with having to wait and added, "I know its bad, but what else can I choose to do? The residents will be upset." Further, DM-A stated the thermometer should not be stored in a cup with pencils and scissors, and should have been sanitized before used to check food temperatures.

On 8/9/18, at 10:30 a.m. a telephone interview was conducted with registered dietician (RD)-A. RD-A expressed food should only be served when hot enough, and she expected facility staff to understand and know the right food temperatures to serve at. Further, RD-A expressed if staff had any question of thermometer function, they should use another thermometer to check it before serving the food.

The facility's Food Thermometer policy dated 7/2018, identified thermometers should be sanitized when removed from the casing, and before being inserted into food and/or fluids. The policy further indicated a water-and-detergent solution should be used to sanitize and remove food debris.

The facility's Food Temperature Monitoring policy dated 7/2018, identified a "Proper holding temperature" was required for food safety and

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listed, "cold food <41 degrees Fahrenheit, hot food >135 degrees Fahrenheit." The policy directed food should be cooked, reheated or cooled to ensure proper holding temperatures before each meal service, and listed a procedure which included the following steps:

- Before meal service, the cook/designee takes the "cook-to" and "serve" temperatures of "...all Time/temperature Control for Safety [TCS] menu items and records on the Food Temperature Record,"

- If temperatures are not within recommended guidelines, food and/or fluids are reheated to acceptable temperatures before service, and,

- TCS hot foods should be served at 135 degrees F or higher.

EQUIPMENT / STORAGE:

On 8/6/18, at 2:15 p.m. an initial kitchen tour was completed with dietary manager (DM)-A. A single, automatic can opener was on the counter which had visible red colored debris and dried substance running down the rear, forward facing backing of the device. A large floor based mixer and bowl was covered with a clear bag. The bag was removed and the mixer inspected which found areas of white colored, dried particles and smeared substance being stuck to the base of the extended arm portion where the mixing shaft is located (directly above the mixing bowl). A single plastic container of powdered sugar was on the counter which was approximately 1/4 full. Inside the container, a stainless steel, round non-handled scoop was sitting on top of the

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F 812	Continued From page 105 powdered sugar. When interviewed at the same time, DM-A acknowledged the observations of the soiled equipment and stated the scoop should not be stored in the container. A provided, undated Day and Evening Cook's listing identified several cleaning tasks to be completed. A bulletpoint directed staff to complete "... any other cleaning that needs to be done," and "kitchen should be spotless when you leave!" In addition, provided weekly cleaning sheets were reviewed and lacked any directed tasks to ensure floors, windows, screens nor fans were included. A policy on food equipment cleaning was requested, but not provided.	F 812		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a clean, sanitary environment which was free of dust and debris in 1 of 1 main production kitchens used to prepare and serve food. In addition, the facility failed to ensure fluid and/or ice dispensing machines were kept in a clean, sanitary manner in 1 of 3 kitchenettes used. These findings had potential to effect affect all 78 residents currently residing in the facility.	F 921	It is the current policy and procedure of GSS-Windom to provide a clean and sanitary environment. The window, fan, and kitchenette equipment were cleaned on Aug. 8, 2018. All the kitchen windows and fans and kitchenette equipment is at risk for this deficient practice and was audited and	9/19/18

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F 921	Continued From page 106 Findings include: KITCHEN: On 8/6/18, at 2:15 p.m. the initial kitchen tour was completed. A crank-style window was observed along the south side of the kitchen next to the dietary manager's office with a visible metallic screen covering the entire, inner aspect of the window. The screen had numerous visible areas of thick clumping dust, with cobwebs and several splatters of white and black colored bird droppings. In addition, a single oscillating fan was attached to the wall in the soiled dishes area. The fan blades' each had visible, clumping black colored dust attached to the surfaces of the blades. The fan was not turned on at this time. During subsequent observation on 8/7/18, at 11:20 a.m. the window screen and fan continued to have the same appearance with visible clumping dust. There was no visible evidence the screen, nor the fan had been cleaned since first observed on 8/6/18. On 8/8/18, at 10:00 a.m. the dietary manager (DM)-C observed and verified the appearance of the window screen and fan in the main production kitchen. DM-C stated the fan was cleaned by maintenance when they were notified to do so, and there was no formal cleaning schedule assigned to it. DM-C expressed it had likely been several weeks since the fan was last cleaned. Further, DM-C stated maintenance would also be responsible to clean the window screen. A provided, undated Day and Evening Cook's listing identified several cleaning tasks to be completed. A bulletpoint directed staff to	F 921	followed up on as appropriate by the Dietary Supervisor for cleanliness on Aug. 8, 2018. The kitchen cleaning schedules and the maintenance cleaning schedules will be audited and updated as necessary by the Maintenance Director, the Dietician, and the Dietary Supervisor on Sept. 11 and 12, 2018. All dietary staff will be re-educated on cleaning practices and their current cleaning schedules which include the kitchenette equipment, on Sept. 12, 2018 by the Dietician and Dietary Supervisor. All maintenance staff will be re-educated by the Maintenance Director on Sept. 11, 2018 on cleaning of windows and fans in the kitchen and the ice maker in the kitchenette, as well as their current cleaning schedules, which include these items. An audit by the QAPI Director or designee will occur of the cleanliness of kitchenette equipment and the kitchen windows and fans, 3x/week for 4 weeks and then weekly x8 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 921	Continued From page 107	F 921		

complete "... any other cleaning that needs to be done," and "kitchen should be spotless when you leave!" In addition, provided weekly cleaning sheets were reviewed and lacked any directed tasks to ensure floors, windows, screens nor fans were included.

No policies on kitchen cleanliness or maintenance were provided.

KITCHENETTE:
On 8/6/18, at 6:00 p.m. the central kitchenette was observed. A single juice machine was on the counter which had one spigot of juice able to be dispensed. The surface area of the machine behind the spigot was visibly soiled with dried, sticky substances running from the spigot area down to the drip tray. In addition, a single automatic ice dispenser was placed on the counter. The machine had visible white colored, flaky, dried sediment extending down the front surface of the device, and extended down and inside the attached drip tray. Further, a dual spigot automatic coffee maker had visible, chalky white colored sediment and debris extending along the seam for several inches where the drip tray attached to the machine.

On 8/7/18, at 8:00 a.m. the kitchenette was observed again. The same observed devices continued to be soiled as previously viewed on 8/6/18, with no evident cleaning being completed.

On 8/8/18, at 10:00 the kitchenette was toured with dietary manager (DM)-A. DM-A acknowledged the findings and stated the area should be cleaned by the evening cooks, and she would let them know.

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GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(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 921	Continued From page 108 DM-A provided a week listing of cleaning duties. The undated Thursday Cleaning Duties listing directed staff to, "Clean up juice machine." Further, Friday Cleaning Duties directed staff to, "Wipe down ice machine sides to." A provided Day and Evening Cooks listing directed the evening cook staff to clean the coffee pots. It did not specify how often this was to be completed.	F 921		

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

F5558027

PRINTED: 09/10/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/08/2018**

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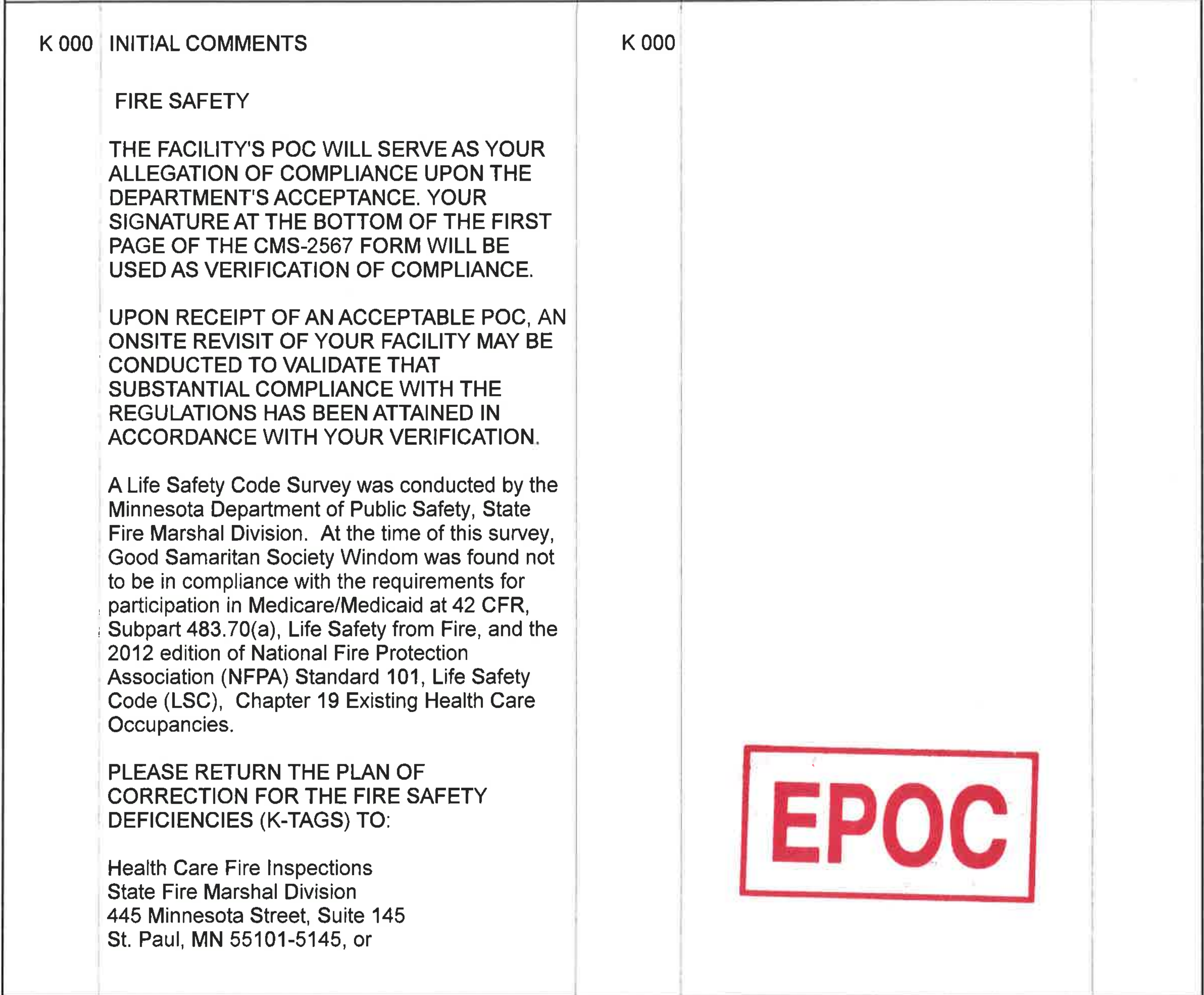
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Windom was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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		09/07/2018

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Windom is a one-story building with partial basement, and was constructed at five different times. The original building was constructed in 1959, with building additions in 1962, 1972, 1994 and 2000. All buildings were determined to be of Type II(111) construction. The facility is fully sprinklered. The building has a fire alarm system with smoke detection in the corridors, including all spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 71 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211	Means of Egress - General	K 211		9/8/18

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

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K 211 SS=E	Continued From page 2 CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with Chapter 7, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 71 of the 71 residents. Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 08/08/2018, observation revealed the pedestrian gate from the North Courtyard was not operable using the handle attached to the gate. This deficient practice was verified by the Facility Maintenance Director.	K 211	K-211 Corrected Date: Aug. 8, 2018 The gate was not able to be used, as it was locked. The gate was unlocked immediately on Aug. 8, 2018 and remains unlocked. Nursing Staff were re-educated by the Maintenance Director on Aug. 8, 2018 to not lock the gate. The lock on the gate will be changed (made inoperable) by Sept. 19, 2018, so it will no longer be at risk. There are no other gates located outside the building. This issue was reported to the Safety Committee for follow-up.	

Electronically delivered
August 29, 2018

Good Samaritan Society - Windom
Attn: Administrator
705 Sixth Street
Windom, MN 56101

Re: State Nursing Home Licensing Orders - Project Numbers S5558026, H5338024

Dear Administrator:

The above facility was surveyed on August 6, 2018 through August 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Holly Kranz, Unit Supervisor at (507) 344-2742 or at holly.kranz@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: ________ B. WING ________	C 08/10/2018

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 6th, 7th, 8th, 9th, and 10th, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		9/19/18

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to notify the physician of a change of condition after a fall with injury for 1 of 3 resident (R16) and bruising which increased in size with swelling for 1 of 1 resident (R24) reviewed . Findings include: R16's Admission Record face sheet identified R16 was admitted to the facility with diagnosis including unspecified convulsions, muscle weakness and a history of falling. R16's Quarterly Minimum Data Set (MDS) assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. R16 was identified as having no pain and no falls since prior assessment 2/23/18. R16's current care plan, last revised 6/18/18, identified R16 had an actual fall with minor injury R/T (related to) urinary tract infection (UTI) with weakness evidenced by fell times 2 on 6/16/18. The goal was identified as resident will resume usual activities without further incident. Interventions included monitor/document/report PRN (as needed) times 72 hours to health care provider for s/s (signs/symptoms) pain, bruises	2 265	Corrected	

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2 265	Continued From page 4	2 265		

and monitor for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. A care plan problem dated 6/20/18, identified the resident had acute pain/discomfort R/T right ankle fracture with surgical repair.

Review of incident report dated 6/16/18, at 5:40 a.m. identified staff went into R16's room after knocking since resident did not put on call light at 5:30 a.m. as per usual. R16 was found sitting on the floor next to the bathroom door frame. Walker next to her. R16 stated she didn't know what happened. Left foot tender to touch, no more swollen than other ankle. R16 not able to bear any weight after assessing ankle, no bruising, able to move ankle back and forth, up and down.

Review of incident report dated 6/16/18, at 7:25 a.m. identified resident was taken to the bathroom as she had her call light on. Staff wheeled R16 into the bathroom. R16 used the grab bar to stand up. Staff moved the wheelchair out of the room so to help resident. Resident suddenly let self slip to the floor. The fall was witnessed. The report also identified the root cause of the fall may have been that R16's left foot was hurting since she had fallen 2 hours earlier. R16 was assisted with the mechanical lift and 2 staff onto bed. Pain rating was identified as 2.

Review of nursing notes are as follows:

6/16/18, 7:36 a.m. Urine specimen was obtained and sent to WAH (local hospital) for U/A (urine analysis) per Dr's order. Urine is cloudy and amber, foul smell.

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2 265	Continued From page 5	2 265		

6/16/18, 7:48 a.m. Ice pack for swelling to left ankle, every 4 hours as needed apply to left ankle for swelling. Having pain in left ankle.

6/16/18, 8:09 a.m. Resident fell twice within 2 hours. Alert but confused, states "I laid there since 10 p.m. last night". She was in bed at 3:30 a.m. as was checked by this writer (staff). There were no screams coming from room as evidence that there was no obvious way she sat there all night. No tears, flat affect, and skin had no reddened areas of pressure. Left ankle was still painful after administration of PRN Tylenol 650 mg. Called primary doctor since she is confused, urine is very foul and incontinent of urine times 2 in last two hours. Used mechanical lift both times to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks.

6/16/18, 8:13 a.m. After second fall in 2 hours, phoned Dr. to inform she had fallen twice, hurt left ankle, no swelling after 2 hours of initial fall and urine has a foul odor. New orders received (orders were for UA to be done).

6/16/18, 8:15 a.m. Applied ice pack to left outer ankle and was brought to dining room for breakfast. Has no complaints of pain while addresses tablemate's at breakfast.

6/16/18, 9:06 a.m. Ice pack for swelling to left ankle every 4 hours as needed. Apply to left ankle for swelling PRN (as needed) administration was effective not swollen but still hurts.

6/16/18, 11:02 a.m. Received phone call from Dr.

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2 265	Continued From page 6	2 265		

regarding UA, ordered Cipro, after resident was given one dose it was noted that she had an allergy, call MD informed him she had allergy to medication. He stated no concern and it shouldn't be a problem, just watch her. MD then changed to Macrobid 100 mg twice daily for 7 days.

6/17/18, 12:02 a.m. Due to not able to bear full weight on left ankle after her fall, now using sit to stand times two assist to use bedside commode. Left ankle not swollen but is painful. Applied ice pack to affected area. Call placed to eLTC (electronic long term care Dr. available via video) for an order to medicate with PRN Tylenol.

6/17/18, 12:04 a.m. Acetaminophen tablet 650 mg give by mouth every 4 hours as needed for pain. Acetaminophen not to exceed 3,000 mg per day. Contact provider/practioner if fever is present. Discomfort in left ankle, rates 5 out of 10 pain.

6/17/18, 12:07 a.m. Ice pack for swelling to left ankle, every 4 hours as needed. Has ice pack to left ankle, not swollen but is very tender to touch.

6/17/18, 12:14 a.m. Phoned eLTC in regards to pain in left ankle. Change of condition after her falls 6/16/18. Spoke with (eLTC staff) about no pain med in orders. Will receive orders via fax.

6/17/18, 1:23 a.m. Acetaminophen was given and effective. Follow up pain score 5.

6/17/18, 2:32 a.m. Ice pack for swelling to left ankle.

6/17/18, 3:29 a.m. Resident was sitting up on edge of bed as writer (staff) went by. Asked

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GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET WINDOM, MN 56101**

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2 265	Continued From page 7 resident to rate her pain, stated it's better now, said feels better than yesterday. Able to bear full weight on affected left foot. Transferred with sit to stand to bathroom. 6/17/18, Acetaminophen 650 mg given for general aches. 6/17/18, 5:33 a. m. Ice pack for swelling to left ankle. Rates the pain in left ankle as 8 out of 10. 6/17/18, 6;05 a.m. Ice pack for swelling. Stated it feels the same. 6/17/18, 7:00 a.m. Acetaminophen 650 mg administration was ineffective pain scale was a 5 "no help at all." 6/17/18, 4:15 p.m. Resident stated I don't think I can stand on my left leg. When transferred with sit to stand lift put most of weight on that leg with no facial grimace or complaints. Denied pain stated it's a little sore. 6/17/18, 9:57 p.m. Resident stated right ankle hurt. Noted a purple bruise on inner right ankle. Will continue to monitor. 6/18/18, 2:03 a.m. Acetaminophen 650 mg given. Up to bathroom able to bear weight on both legs but stated "very painful." 6/18/18, 2:12 a.m. Ice pack applied to both ankles. 6/18/18 2:16 a.m. Stated "I hurt my right ankle and can't stand on my leg". When placed in sit to stand lift for transfer placed most of weight on that leg with no facial grimace or complaints. Has discoloration of the inner right foot. Stated its a	2 265		

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little sore scant swelling bilateral feet.

6/18/18, 2:48 a.m. Ice pack for swelling to left ankle. Took the patchiness away.

6/18/18, 6:58 a.m. Acetaminophen 650 mg given. Pain scale 9. Resident stated no relief to right leg and ankle pain.

6/18/18, 7:30 a.m. Resident complained of severe right leg pain, requesting analgesics.

6/18/18, 8:29 a.m. Pain scale 10. Resident stated no relief from pain.

6/18/18, 11:57 a.m. Acetaminophen 650 mg given. Resident complained of severe right leg and ankle pain.

6/18/18, 1:36 p.m. Acetaminophen 650 mg PRN administration was ineffective. Pain scale 10 resident stated not having any relief.

6/18/18, 8:03 p.m. Acetaminophen 650 mg given.

6/18/18, 11:06 p.m. Acetaminophen 650 mg followup. ineffective pain scale 5 still hurting badly.

6/19/18, 12:03 a.m. Very painful when assessing right foot which now is bruised entirely around the ankle and top of foot is swollen more than last two days. Rather than bear weight on it will use bed pan tonight. Will get X-ray tomorrow.

6/19/18, 5:09 a.m. Has been using the bed pan to void tonight since she is having so much pain in both feet. Now total lift of mechanical lift with 2 assist to raise up off the bed to change soiled chux. Resident will not turn, insists she's in too

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much pain to move. Medicated with PRN Tylenol (Acetaminophen) 650 mg for severe discomfort.

6/19/18, 5:10 a.m. Pain is so extreme that the resident needs to be raised in bed using mechanical lift. Noted a bruise on under side of left breast.

6/19/18, 6:39 a.m. Has a whirlpool bath. Two assist out of bed with sit to stand lift. Right foot is swollen +2 and bruised Did have a lot of pain when transferred from bed to wheelchair.

6/19/18, 6:39 a.m. Acetaminophen 650 mg was ineffective. Pain scale 8. Resident continues to rate pain severe.

6/19/18, 9:17 a.m. faxed MD questioning if needs x-ray right foot related to swelling, bruising and pain following fall of 6/16/18.

6/19/18, 2:41 p. m. Fax received from MD that may obtain x-ray of right foot/ankle.

6/19/18, Called family member and informed of x-ray of right foot/ankle scheduled at hospital for 6/20/18 at 11:00 a.m.

6/19/18, 8:10 p.m. Acetaminophen 650 mg given for ankle pain.

6/20/18, 12:19 a.m. Asleep at this time.

6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain.

6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief.

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6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair.

6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resdient complained of moderate pain in right ankle. Requesting analgesics.

6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5.

6/20/18, 4:30 p.m. Discussed pain with residnet and stated not so bad mostly hurts when I lie down and put covers on it. Stated splint supports it and is more comfortable.

6/20/18, 8:18 p.m. Acetaminophen 650 mg given for pain scale of 4.

6/21/18, 3:10 a.m. Acetaminophen 650 mg given.

6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8.

6/21/18, 8:15 a.m. TO hospital for surgery right ankle.

6/21/18, 7:05 p.m. Returned from hospital where she had right ankle repair about 6:30 p.m. She is in a wheelchair. Right foot is splinted and wrapped with ace. Rates pain at 8 of 10. Will medicate when meds arrive.

6/21/18, 8:30 p.m. Given Ketorolac 10 mg for pain level of 8.

An order from eLTC dated 6/17/18, at 1:00 a.m. identified nurse called requesting order for Tylenol

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for pain. Patient recently sprained her left ankle, had an order for ice but no order for pain medication. At this time Acetaminophen 325 mg two tablets every 4 hours PRN pain was ordered.

A fax was sent to the MD on 6/16/18, at 5:40 a.m. The fax identified R16 was found on the floor walking to the bathroom with 4 wheeled walker. ROM (range of motion) to left ankle painful when putting pressure on foot, no swelling. Does not want to stand on left ankle. No bruising. The fax was faxed back to the facility on 6/18/18, at 12:20 p.m. with physician comment, "I was called about this, I assume all is now well. Yes? The fax was noted as received back at facility 6/18/18. No reply was sent to the physician regarding pain and swelling of right ankle.

Review of the x-ray results dated 6/20/18, identified a Weber type B distal fibular/lateral malleolar fracture or the right ankle.

Review of pain assessment dated 6/18/18, identified pain associated with a diagnosis or condition, non-pharmacological interventions of ice and rest. The assessment also identified the current medication regime of PRN Tylenol 650 mg and ice PRN was not working.

During interview with the director of nursing (DON) on 8/9/18, at 10:24 a.m. she stated staff should have been in touch with the Dr. in a more timely way than faxing. She verified no follow up was done as far as pain medication not being effective, pain status, change in condition and what was being done to treat her. She stated with complaints of pain something obviously changed since there was swelling and bruising. She stated R16 was independent in her room with walking prior to the falls but after the falls she

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needed to be transferred with mechanical lift and 2 assist. She stated the MD should have been called back on 6/18/18, when we received the fax back and told about the increased pain and swelling and change in condition. She stated when they faxed on the 19th about an x-ray they should have called and not faxed the Dr. to get her in for an x-ray that day. She stated they saw bruising on the 17th, first on the left then on the right which should have been addressed. She stated we have pain meds in the e kit we could have used to make her more comfortable since the Tylenol was obviously not working for pain control.
During interview with the attending physician on 8/14/18, at 3:22 p.m. he stated he should have been notified of the increased pain and swelling of the ankle. He stated he was notified of the fall the morning it happened. He stated he did not see the fax from the 16 until Monday morning the 18th. At that time he stated I responded back and asked if everything was ok. He stated I did not hear anything back from them until they asked for an x-ray on the 19th.

Review of the policy Notification of Change dated 11/2016, indicates the facility must immediately consult with the residents physician when there is a significant change in the residents physical, mental or psychosocial status and a need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment.

R24

R24's quarterly Minimum Data Set (MDS) dated 6/1/18, indicated R24 had severe cognitive impairment and required extensive assist of two staff for bed mobility, transfers and dressing.

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R24's Medication Administration Record (MAR) dated August 2018, identified R24 received aspirin 81 milligrams (mg) on a daily basis.

R24 was interviewed on 8/6/18, at 3:30 p.m. and explained he developed a bruise on his left arm, which caused him some occasional pain. R24 did not know how he obtained the bruise, and felt it was getting bigger in size.

R24's skin care plan initiated 7/31/18, indicated R24 had bruising on their left upper arm with interventions for the staff to follow including to monitor the location and size of the bruise, and report abnormalities and/or lack of healing to the physician.

R24's incident report dated 7/30/18, identified R24 developed a bruise on his left arm, which measured 15 centimeters (cm) by 14 cm in size. R24 was recorded as saying, "it hurts."

R24's progress notes identified the following entries:

On 7/30/18, R24 was recorded as having a, "Large discolored area on left upper arm that is dark in color and yellowish towards the posterior arm. Resident says, 'My whole arm hurts' ... Etiology unknown." Later on 7/30/18, R24's physician progress note identified R24 had been seen by the physician for the bruising who ordered staff to monitor the area.

On 7/31/18, "Left upper arm is discolored and appears slight swollen. He did not acknowledge any pain in shoulder as he did yesterday."

On 8/5/18, "Update on impaired skin integrity.

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Bruising on his [left] upper extremity was noted that it had spread down to just distal of the elbow. Swelling noted around the elbow as well. The bruising towards the shoulder is healing and lightening up, starting to get yellowish coloration. He states he has no pain in the arm unless he extends and brings extremity backwards, rated moderate pain. Ice was applied to elbow and pain is being managed with scheduled Tylenol. Will continue to monitor."

On 8/6/18, "[left] arm bruising noted that it had spread down to entire arm. Swelling noted around elbow. Denies any pain."

R24 was observed on 8/8/18, at 7:00 a.m. seated in the hallway in a wheelchair. R24 was assisted to his room, and registered nurse (RN)-D assisted him to remove his shirt. R24 had visible yellow bruising on his front upper shoulder extending down his arm approximately three inches, followed by dark purple, at times almost black colored, bruising extending down and around R24's left arm and wrist area, covering the top of the left hand. In addition, R24's entire left arm was swollen with noticeably localized swelling in the elbow region when compared to his right arm. RN-D stated she had observed the bruise when it was first identified on the incident report, however, explained she was not aware if anyone had updated R24's physician about the bruising since it was first identified.

On 8/08/18, at 8:11 a.m. nursing assistant (NA)-A stated she was aware R24 had bruising on his left arm, and he had been complaining of pain when using his left arm to push himself up in bed during cares.

On 8/8/18, at 8:25 a.m. registered nurse (RN)-A

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stated the bruising "appeared a couple of weeks ago" and she was not concerned with it as, "It's gotta work its way down but its fading." RN-A expressed she was unaware if R24's physician had been notified of the bruising since it developed, however, did not feel it had worsened or that current interventions were not working.

On 8/8/18, at 8:44 a.m. during a phone interview, R24's medical doctor (MD)-A stated he expected the facility to notify him of changes to a resident including when bruising and/or swelling changed so treatment could be considered.

On 8/8/18, at 9:00 a.m. the director of nursing (DON) stated she expected staff to notify the physician when they identified a significant change, which was "something that is more than a natural gravity change." The DON stated MD-A would be coming to the facility today to observe R24's bruising.

On 8/8/18, at 12:32 p.m. during a follow-up interview, MD-A stated he had observed R24's left arm bruising and ordered an ACE wrap and ice to be applied. MD-A stated he "would have expected to have been notified of this change."

A Notification of Change policy dated 11/2016, identified the staff should consult with the residents' physician when there is any significant change in their physical, mental or psychosocial status.

SUGGESTED METHOD OF CORRECTION:
The DON or designee could develop and monitor policies and procedures to ensure practioners are notified of changes in residents condition accurately. The DON or designee could educate all appropriate staff on these policies and

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2 265	Continued From page 16 procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 265		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide sufficient nursing staff to provide and meet assessed needs for 1 of 4 residents (R48) reviewed for pressure ulcers; 1 of 1 resident (R41) reviewed for hospice; 1 of 5 residents (R16) reviewed for accidents; 1 of 1 resident (R7) reviewed for edema; 3 of 3 residents (R4, R48, R54) reviewed for activities of daily living (ADLs); and 1 of 1 resident (R39) reviewed for position mobility. In addition, 3 of 3 residents (R16, R39, R58), 1 of 3 family members (FM-G), and 6 of 6 staff members (RN-C, LPN-A, TMA-A, NA-D, NA-H, NA-I) voiced concerns with the lack of sufficient nursing staff in the facility. The lack of sufficient nursing staff had the potential to affect all 70	2 800	Corrected	9/19/18

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residents in the facility along with visitors and staff.

Findings include:

Pressure Ulcers:

R48 was not comprehensively assessed and pressure relieving interventions were not implemented. On 8/8/18, R48 was continuously observed from 7:15 a.m. until 9:38 a.m. lying in a recliner in the dining area. Staff were assisting other residents in and out of the dining room and providing breakfast during that time. R48 had one leg on the footrest of the recliner with the other leg hanging down with one shoe off and one shoe on. R48 would move his legs periodically and would make moaning/humming type sounds. At 9:38 a.m., nursing assistant (NA)-D approached R48 and asked if he was ready to get up; the resident responded he was. NA-D and NA-F pivot transferred R48 into his wheelchair (w/c) which had a pressure reducing waffle air cushion on the seat. The resident's recliner did not have a pressure reducing cushion on the seat. NA-D then propelled R48 into the tub room to be toileted. NA-D indicated the night aide (NA-J) had already completed R48's morning cares earlier when assisted with toileting around 6:00 a.m. (approximately 3 1/2 hours earlier). NA-D and NA-F transferred R48 onto the toilet. Once R48 was finished with toileting, NA-D and NA-F stood the resident up to provide peri-care. R48's bottom was observed to have 2 small open red areas, one on the coccyx and one on the right upper buttock near the crease; the areas were circular and approximately 0.5 centimeters (cm) in diameter. When asked if the areas were new, NA-D indicated they were new to her. NA's then

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2 800	Continued From page 18 sat the resident back down onto the toilet and alerted the nurse to come into the tub room to observe the resident's bottom. Licensed practical nurse (LPN)-B entered the tub room and confirmed R48 had 2 open areas on his bottom. LPN-B stated the areas were new to her but would have to research the resident's medical record to make sure they had not been there prior to today. LPN-B then instructed the NA's to feed the resident breakfast first prior to providing treatment or measuring the open areas. When interviewed immediately following the observation, NA-D confirmed R48 always slept in the recliner in the dining area. NA-D stated when the resident first came to the facility they would attempt to have him sleep in the recliner in his room as the resident slept in a recliner at home. R48 would crawl out of the recliner in his room and come out to the recliner in the dining area to sleep. Per R48's preference, they continued to have him sleep in the recliner in the dining area. When interviewed on 8/8/18, at 10:27 a.m. NA-D stated staff try to reposition R48 every 2 hours though sometimes it can be longer. NA-D further stated sometimes the resident was resistive to being reposition and other days he was up and on the move. Fax to physician dated 8/8/18, and sent at 11:34 a.m. indicated: Has an open area on his coccyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or soiled. Fax was returned to the facility 8/9/18 at 10:07 a.m. with physician approval of the order. On 8/8/18, at 1:10 p.m. R48 was observed laying in recliner in the dining room with knees bent and eyes closed. When interviewed at that time NA-D	2 800		

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confirmed the resident was transferred into the recliner at approximately 12:50 p.m. NA-D further confirmed LPN-B had not yet measured or done any type of treatment to the open areas on R48's bottom as was awaiting direction from the registered nurse case manager (RN)-C.

When interviewed on 8/8/18, at 1:57 p.m. LPN-B stated she had applied a hydrocolloid dressing to the open area on R48's coccyx. LPN-B stated the dressing was large enough to cover the smaller superficial reddish areas below the coccyx as well. When asked about the other open area on R48's right upper buttock, LPN-B stated not realizing the resident had more than one open area. LPN-B then stated she would be back to work tomorrow morning and could look at it then. LPN-B confirmed she had not measured the open area on R48's coccyx as staff was having a difficult time keeping the resident standing during the treatment. LPN-B stated the open area on the coccyx was approximately 0.5 cm round in diameter. LPN-B confirmed R48 had never utilized a pressure reducing cushion when in the recliner.

On 8/9/18, at 8:56 a.m. NA-H and NA-D were observed getting R48 up out of his recliner to perform morning cares. The NA's utilized a standing lift to transfer R48 into his w/c. R48's w/c had a pressure reducing waffle air cushion on the seat with very little air in the cushion; the recliner did not have a pressure reducing cushion on the seat. R48 was then propelled into the tub room to be toileted and assisted with cares. NA's utilized the standing lift to transfer the resident onto the toilet, NA-H removed R48's brief, which was soiled with bowel movement. NA-D asked NA-H if there was a duoderm dressing on the resident's bottom and NA-H informed her there

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2 800	Continued From page 20 was not. After assisting R48 with washing up and changing clothes for the day, NA-D and NA-H then raised the resident up to a standing position with the lift and provided peri-care. R48 hollered out "Ow!" while his bottom was being cleansed. R48's bottom was observed; there was no dressing covering the resident's coccyx. R48 had two open areas on the coccyx, the upper open area on the coccyx was new since the observation on 8/8/18. The lower open area on the coccyx was larger with white slough covering the wound bed. The area on the right upper buttock near the crease had decreased in size, was reddened and appeared to be closed, there was another small reddened area next to it. NA's put the call light on to alert the nurse. LPN-A entered the room and measured the open area's on R48's coccyx. The new upper area on the coccyx measured 1.0 cm and was circular, the lower open area measured 1.8 cm x (by) 1.0 cm. LPN-A also identified the small reddened areas on R48's right buttock though felt they were scratches. LPN-A applied skin prep to R48's coccyx then covered the open areas with a hydrocolloid dressing. NA-H then finished dressing R48 and transported him to the dining room for breakfast. When interviewed on 8/9/18, at 10:49 a.m. NA-E stated R48 was to be repositioned every 2 hours just like all the other residents on the unit. When interviewed on 8/9/18, at 10:55 a.m. LPN-A stated he was told when coming on duty today that RN-C wanted him to take a good look at R48's bottom as it had been reported there was an open area. LPN-A stated other than that there were no new interventions as was to inform RN-C of what he observed and then she would take it from there.	2 800		

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2 800	Continued From page 21 When interviewed on 8/9/18, at 10:59 a.m. RN-C stated LPN-B had reported R48 had an open area on the coccyx, was unable to measure the area due to the resident becoming uncooperative though was able to cover the area with a duoderm dressing. RN-C stated she had updated R48's care plan indicating the resident was to be repositioned once awake, before and after meals, for the 3:00 p.m. activity in the afternoon, and at HS (bedtime). RN-C confirmed approximately every 2 hours as R48 allowed. RN-C stated in the morning staff usually wait until R48 had his eyes open and was ready to get up. RN-C further stated staff do not push it and if R48 was resistive, they let him sleep. RN-C stated also implementing R48's pressure reducing cushion to be utilized when the resident was in the recliner as well as the w/c. RN-C stated prior to this a pressure reducing cushion had not been utilized in R48's recliner as did not think it necessary as the recliner cushion was soft. RN-C confirmed the pressure reducing cushion should have been utilized in R48's recliner last night and was not sure why it was not. RN-C further confirmed R48's dressing should have been replaced when the old fell off and that staff should be monitoring when the pressure reducing air cushions were deflating and needed more air. RN-C stated LPN-A was usually the one to do this as he also worked as a restorative therapy nurse. When interviewed on 8/9/18, at 1:48 p.m. LPN-A confirmed R48's pressure reducing waffle air cushion was on the low side and definitely needed more air in it. LPN-A stated it was nursing's responsibility to monitor the cushions and make sure they were inflated adequately. LPN stated when the next shift came on at 2:30 p.m. he would have them take the cushion down	2 800		

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to therapy to be inflated and to pick up an extra cushion to keep in the resident's recliner.

Review of the Wound Data Collection dated 8/9/18 by LPN-A identified R48's open areas on the coccyx as moisture associated wounds. When interviewed on 8/10/18, at approximately 10:00 a.m. RN-C confirmed she had not yet visualized R48's open areas on the coccyx and could not say for sure if they were moisture associated or pressure wounds. RN-C further confirmed an RN had not assessed R48's open areas.

During observation on 8/10/18, at 10:38 a.m. RN-C and the director of nursing (DON) confirmed R48 had two stage 2 pressure ulcers on his coccyx and a small 0.5 cm open area on the inner right buttock.

When interviewed on 8/10/18, at 10:54 a.m. the DON provided documentation of the process staff were to follow when a new skin issue was discovered. DON stated she would expect staff to notify the RN case manager right away and to fax the physician of the skin issue. DON stated the RN case manager should evaluate the area as soon as she could to assess and to provide the appropriate treatment and interventions. DON reviewed R48's Mobilization Support Data Collection Tool dated 6/28/18. DON stated much of the tool did not apply to R48 as he did not sleep in bed and was on his seat much of the time therefore should have been looked at a little differently in terms of positioning. DON confirmed a Positioning Assessment and Evaluation had not been completed for R48 to determine an individualized repositioning schedule. DON confirmed when R48 no longer utilized his bed the care plan should have been

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updated and would have expected a pressure reducing cushion to be utilized in the recliner. DON stated with repositioning would need to see how well R48 slept and what that pattern looked like and go from there, though would start with every hour and a half to 2 hours repositioning. As far as how often to reposition at night if the resident was sleeping would depend upon if he had a good cushion and had pressure mapping completed by physical therapy. DON confirmed that had not been completed for R42. DON confirmed staff should be monitoring for the appropriate amount of air in the cushion R48 was utilizing. DON confirmed an RN should have completed an assessment on the wound when first identified. DON stated when there are new interventions for residents' it will go on the care plan and it will come out with a "k" and that will transfer to the kardex so the NA's can see them on the kiosk - there was also a 24 communication written at the station for staff as well. DON stated the NA's should have known to utilize the cushion in his recliner once implemented into the care plan.

SEE F686 FOR ADDITIONAL INFORMATION

Pain Management

R16 was not provided care and services in a timely manner to treat an injury resulting from a fall that resulted in a fractured ankle. Review of incident report dated 6/16/18, at 5:40 a.m. identified staff went into R16's room after knocking since resident did not put on call light at 5:30 a.m. as per usual. R16 was found sitting on the floor next to the bathroom door frame. Walker next to her. R16 stated she didn't know what happened. Left foot tender to touch, no more swollen than other ankle. R16 not able to

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bear any weight after assessing ankle, no bruising, able to move ankle back and forth, up and down.

Review of incident report dated 6/16/18, at 7:25 a.m. identified resident was taken to the bathroom as she had her call light on. Staff wheeled R16 into the bathroom. R16 used the grab bar to stand up. Staff moved the wheelchair out of the room so to help resident. Resident suddenly let self slip to the floor. The fall was witnessed. The report also identified the root cause of the fall may have been that R16's left foot was hurting since she had fallen 2 hours earlier. R16 was assisted with the mechanical lift and 2 staff onto bed. Pain rating was identified as 2.

Review of nursing notes are as follows:
6/16/18, 7:36 a.m. Urine specimen was obtained and sent to WAH (local hospital) for U/A (urine analysis) per Dr's order. Urine is cloudy and amber, foul smell.

6/16/18, 7:48 a.m. Ice pack for swelling to left ankle, every 4 hours as needed apply to left ankle for swelling. Having pain in left ankle.

6/16/18, 8:09 a.m. Resident fell twice within 2 hours. Alert but confused, states "I laid there since 10 p.m. last night". She was in bed at 3:30 a.m. as was checked by this writer (staff). There were no screams coming from room as evidence that there was no obvious way she sat there all night. No tears, flat affect, and skin had no reddened areas of pressure. Left ankle was still painful after administration of PRN Tylenol 650 mg. Called primary doctor since she is confused, urine is very foul and incontinent of urine times 2 in last two hours. Used mechanical lift both times

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to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks.

6/16/18, 8:13 a.m. After second fall in 2 hours, phoned Dr. to inform she had fallen twice, hurt left ankle, no swelling after 2 hours of initial fall and urine has a foul odor. New orders received (orders were for UA to be done).
6/16/18, 8:15 a.m. Applied ice pack to left outer ankle and was brought to dining room for breakfast. Has no complaints of pain while addresses tablemate's at breakfast.
6/16/18, 9:06 a.m. Ice pack for swelling to left ankle every 4 hours as needed. Apply to left ankle for swelling PRN (as needed) administration was effective not swollen but still hurts.
6/16/18, 11:02 a.m. Received phone call from Dr. regarding UA, ordered Cipro, after resident was given one dose it was noted that she had an allergy, call MD informed him she had allergy to medication. He stated no concern and it shouldn't be a problem, just watch her. MD then changed to Macrobid 100 mg twice daily for 7 days.
6/17/18, 12:02 a.m. Due to not able to bear full weight on left ankle after her fall, now using sit to stand times two assist to use bedside commode. Left ankle not swollen but is painful. Applied ice pack to affected area. Call placed to eLTC (electronic long term care Dr. available via video) for an order to medicate with PRN Tylenol.
6/17/18, 12:04 a.m. Acetaminophen tablet 650 mg give by mouth every 4 hours as needed for pain. Acetaminophen not to exceed 3,000 mg per day. Contact provider/practioner if fever is present. Discomfort in left ankle, rates 5 out of

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10 pain.
6/17/18, 12:07 a.m. Ice pack for swelling to left ankle, every 4 hours as needed. Has ice pack to left ankle, not swollen but is very tender to touch.

6/17/18, 12:14 a.m. Phoned eLTC in regards to pain in left ankle. Change of condition after her falls 6/16/18. Spoke with (eLTC staff) about no pain med in orders. Will receive orders via fax.

6/17/18, 1:23 a.m. Acetaminophen was given and effective. Follow up pain score 5.

6/17/18, 2:32 a.m. Ice pack for swelling to left ankle.

6/17/18, 3:29 a.m. Resident was sitting up on edge of bed as writer (staff) went by. Asked resident to rate her pain, stated it's better now, said feels better than yesterday. Able to bear full weight on affected left foot. Transferred with sit to stand to bathroom
.
6/17/18, Acetaminophen 650 mg given for general aches.

6/17/18, 5:33 a. m. Ice pack for swelling to left ankle. Rates the pain in left ankle as 8 out of 10.

6/17/18, 6;05 a.m. Ice pack for swelling. Stated it feels the same.

6/17/18, 7:00 a.m. Acetaminophen 650 mg administration was ineffective pain scale was a 5 "no help at all."

6/17/18, 4:15 p.m. Resident stated I don't think I can stand on my left leg. When transferred with sit to stand lift put most of weight on that leg with no facial grimace or complaints. Denied pain

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stated it's a little sore.

6/17/18, 9:57 p.m. Resident stated right ankle hurt. Noted a purple bruise on inner right ankle. Will continue to monitor.

6/18/18, 2:03 a.m. Acetaminophen 650 mg given. Up to bathroom able to bear weight on both legs but stated "very painful."

6/18/18, 2:12 a.m. Ice pack applied to both ankles.

6/18/18 2:16 a.m. Stated "i hurt my right ankle and can't stand on my leg". When placed in sit to stand lift for transfer placed most of weight on that leg with no facial grimace or complaints. Has discoloration of the inner right foot. Stated its a little sore scant swelling bilateral feet.

6/18/18, 2:48 a.m. Ice pack for swelling to left ankle. Took the patchiness away.

6/18/18, 6:58 a.m. Acetaminophen 650 mg given. Pain scale 9. Resident stated no relief to right leg and ankle pain.

6/18/18, 7:30 a.m. Resident complained of severe right leg pain, requesting analgesics.

6/18/18, 8:29 a.m. Pain scale 10. Resident stated no relief from pain.

6/18/18, 11:57 a.m. Acetaminophen 650 mg given. Resident complained of severe right leg and ankle pain.

6/18/18, 1:36 p.m. Acetaminophen 650 mg PRN administration was ineffective. Pain scale 10 resident stated not having any relief.

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2 800	Continued From page 28 6/18/18, 8:03 p.m. Acetaminophen 650 mg given. 6/18/18, 11:06 p.m. Acetaminophen 650 mg follow up. ineffective pain scale 5 still hurting badly . 6/19/18, 12:03 a.m. Very painful when assessing right foot which now is bruised entirely around the ankle and top of foot is swollen more than last two days. Rather than bear weight on it will use bed pan tonight. Will get X-ray tomorrow. 6/19/18, 5:09 a.m. Has been using the bed pan to void tonight since she is having so much pain in both feet. Now total lift of mechanical lift with 2 assist to raise up off the bed to change soiled chux. Resident will not turn, insists she's in too much pain to move. Medicated with PRN Tylenol (Acetaminophen) 650 mg for severe discomfort. 6/19/18, 5:10 a.m. Pain is so extreme that the resident needs to be raised in bed using mechanical lift. Noted a bruise on under side of left breast. 6/19/18, 6:39 a.m. Has a whirlpool bath. Two assist out of bed with sit to stand lift. Right foot is swollen +2 and bruised Did have a lot of pain when transferred from bed to wheelchair. 6/19/18, 6:39 a.m. Acetaminophen 650 mg was ineffective. Pain scale 8. Resident continues to rate pain severe. 6/19/18, 9:17 a.m. faxed MD questioning if needs x-ray right foot related to swelling, bruising and pain following fall of 6/16/18. 6/19/18, 2:41 p. m. Fax received from MD that	2 800		

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may obtain x-ray of right foot/ankle.

6/19/18, Called family member and informed of x-ray of right foot/ankle scheduled at hospital for 6/20/18 at 11:00 a.m.

6/19/18, 8:10 p.m. Acetaminophen 650 mg given for ankle pain.

6/20/18, 12:19 a.m. Asleep at this time.

6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain.

6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief.

6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair.

6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resdient complained of moderate pain in right ankle. Requesting analgesics.

6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5.

6/20/18, 4:30 p.m. Discussed pain with residnet and stated not so bad mostly hurts when I lie down and put covers on it. Stated splint supports it and is more comfortable.

6/20/18, 8:18 p.m. Acetaminophen 650 mg given for pain scale of 4.

6/21/18, 3:10 a.m. Acetaminophen 650 mg given.

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2 800	Continued From page 30 6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8. 6/21/18, 8:15 a.m. TO hospital for surgery right ankle. 6/21/18, 7:05 p.m. Returned from hospital where she had right ankle repair about 6:30 p.m. She is in a wheelchair. Right foot is splinted and wrapped with ace. Rates pain at 8 of 10. Will medicate when meds arrive. 6/21/18, 8:30 p.m. Given Ketorolac 10 mg for pain level of 8. An order from eLTC dated 6/17/18, at 1:00 a.m. identified nurse called requesting order for Tylenol for pain. Patient recently sprained her left ankle, had an order for ice but no order for pain medication. At this time Acetaminophen 325 mg two tablets every 4 hours PRN pain was ordered. A fax was sent to the MD on 6/16/18, at 5:40 a.m. The fax identified R16 was found on the floor walking to the bathroom with 4 wheeled walker. ROM (range of motion) to left ankle painful when putting pressure on foot, no swelling. Does not want to stand on left ankle. No bruising. The fax was faxed back to the facility on 6/18/18, at 12:20 p.m. with physician comment, "I was called about this, I assume all is now well. Yes? The fax was noted as received back at facility 6/18/18. No reply was sent to the physician regarding pain and swelling of right ankle. Review of the x-ray results dated 6/20/18, identified a Weber type B distal fibular/lateral malleolar fracture or the right ankle.	2 800		

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2 800	Continued From page 31 Review of pain assessment dated 6/18/18, identified pain associated with a diagnosis or condition, non-pharmacological interventions of ice and rest. The assessment also identified the current medication regime of PRN Tylenol 650 mg and ice PRN was not working. During interview with the director of nursing (DON) on 8/9/18, at 10:24 a.m. she stated staff should have been in touch with the Dr. in a more timely way than faxing. She verified no follow up was done as far as pain medication not being effective, pain status, change in condition and what was being done to treat her. She stated with complaints of pain something obviously changed since there was swelling and bruising. She stated R16 was independent in her room with walking prior to the falls but after the falls she needed to be transferred with mechanical lift and 2 assist. She stated the MD should have been called back on 6/18/18, when we received the fax back and told about the increased pain and swelling and change in condition. She stated when they faxed on the 19th about an x-ray they should have called and not faxed the Dr. to get her in for an x-ray that day. She stated they saw bruising on the 17th, first on the left then on the right which should have been addressed. She stated we have pain meds in the e kit we could have used to make her more comfortable since the Tylenol was obviously not working for pain control. During interview with the attending physician on 8/14/18, at 3:22 p.m. he stated he should have been notified of the increased pain and swelling of the ankle. He stated he was notified of the fall the morning it happened. He stated he did not see the fax from the 16 until Monday morning the 18th. At that time he stated I responded back	2 800		

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and asked if everything was ok. He stated I did not hear anything back from them until they asked for an x-ray on the 19th.

Review of the policy Notification of Change dated 11/2016, indicates the facility must immediately consult with the residents physician when there is a significant change in the residents physical, mental or psychosocial status and a need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment.

Hospice Coordination:

The facility failed to coordinate hospice services for R41. R41's medical director certification/recertification dated 6/7/18, identified a hospice start of care date of 3/18/18, with diagnosis of senile degeneration of the brain.

R41's significant change MDS dated 3/23/18, identified R41 had a severely impaired cognition and total dependence in all activities of daily living. The MDS also identified R41 was receiving hospice services.

R41's care plan revised 4/3/18, identified R41 had a terminal prognosis related to end stage dementia and was receiving hospice care. Interventions included, assess resident and family coping skills, contact hospice staff for support as needed, work with nursing staff to provide maximum comfort for the resident.

At the nurses stations on a clip board under numerous papers was a paper that said attention facility staff! R41 is under the care of (name of hospice). The team was identified as nurse, social worker and chaplain. No aide or volunteer

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was identified. Another paper was under the first on that said (name of hospice) nurse-weekly visits on Monday, Aide- provides AM ADL cares Monday thru Friday. Chaplain/SS (social service) Thurs/Fri. No patient name is identified on this paper nor are times . The hospice agency plan of care provided by the facility did not have any a visit schedule on it.

During observation on 8/8/18, at 7:05 a.m. hospice aide was present giving R41 a bath. At 7:43 a.m. R41 was sitting at the breakfast table being fed by a staff member. Hospice aide left after giving R41 her bath.

During observation on 8/9/18, at 7:47 a.m. hospice aide was present feeding R41.

During interview on 8/8/18, at 8:13 a.m. nursing assistant (NA)-D stated we don't know what they are going to do when they come. For instance today they couldn't feed her because they had to go do something else. Sometimes they give her a bath and feed her, sometimes they just feed her. We never know. We don't know days or times they come either. Sometimes they tell us sometimes they don't. I think they are supposed to come 3 days a week or something but they maybe only come two. We never know what time. sometimes it's 6 a.m. when they are supposed to be her at 8, we never know. They have come at like 4 in the afternoon before too.

During interview on 8/8/18, at 8:30 a.m. NA-F stated you never know around here when they will come. Sometimes they come and then they have to leave because they have to go somewhere else so they don't do everything they are supposed to. If they can't make it they don't tell us they just come another day.

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2 800	Continued From page 34 During interview on 8/8/18, at 9:00 a.m. RN-C stated well there is a calendar at the desk. The aide comes every morning Monday through Friday between 6 and 8 a.m. they have a chaplain and a social worker that come later part of the week. The nurse comes on Tuesday, she was here yesterday. She has a volunteer that comes a lot. If they can't make it they don't tell us they just come another day. My hospice people are stable so I'm not concerned about it. If they do let the nurse know they aren't coming then the aides should be told that too. During interview on 8/8/18 at 9:28 a.m. licensed practical nurse (LPN)-B stated she did not know where the calendar for hospice was located to know when they came. RN-B came onto unit and stated the calendar is under the clip board. During interview on 8/09/18, at 7:47 a.m. hospice aide (HA)-A stated we are here 5 days per week for R41. She stated I come at 5:30 because I have another patient here. We have 5 different aides and we all have different schedules. It depends on where the clients are and who has them as to when they come. If I do morning cares then I don't feed and if I don't do morning care then I feed her breakfast, play music, curl her hair. Normally her bath is done so then I feed her. Yesterday I had to go because we were short someone called in so we had to split visits up so I had to go. She stated I don't talk to the staff really unless something out of the ordinary. I just come in and go to her room and help her. If I need to tell them something I will, like if something is different or out of the ordinary. During interview on 8/9/18, at 12:47 p.m. she stated the hospice should give us a schedule. We need to tell them we don't know when their	2 800		

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people are coming. That is not good communication for continuity of care.

Edema:

The facility failed to monitor edema (fluid retention) R7 with edema in feet/ankles. R7's diagnosis report dated 8/10/18, included diagnoses of edema, macular degeneration (an eye disease that causes vision loss), and dementia.

Review of R7's current physican orders dated 6/12/18, included Lasix (a medication to reduce extra fluid in the body) 80 milligram (MG) daily for edema.

During observation on 8/8/18, at 12:50 p.m., R7 was observed to have bilateral edema in her feet and ankles. The resident was sitting in a recliner chair in her room with her feet resting on the floor. The resident had velcro closing shoes and grippy socks on, however there was visible indentation to R7's ankles from the grippy socks. The right ankle also had a reddened appearance.

During observation on 8/9/18, at 8:46 a.m. nursing assistant (NA)-C transferred R7 into a recliner chair. R7 was wearing socks and shoes, however visible bilateral edema to ankles was noted, and her feet remained on the floor when NA-C left the room.

During interview on 8/8/18, at 10:04 a.m. NA-C confirmed R7 had edematous ankles. NA-C further stated there were no specific interventions for the edema but indicated R7 would elevate her feet if she wanted to.

During interview on 8/8/18, at 1:09 p.m.

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registered nurse (RN)-B indicated R7 had long standing edema to her lower extremities. RN-B confirmed there was no formal monitoring in place for the edema.

During observation and interview on 8/9/18, at 2:22 p.m., R7 was sitting in her recliner chair with her feet on the ground. RN-C assessed R7's lower extremities stating they were cool and dry. RN-C further verified right lower extremity had a redness present but no warmth or discomfort noted from R7. RN-C identified R7 had two plus pitting edema (swelling that is significant enough to cause an indentation of 3-4 millimeters deep in the skin when depressed with a finger) in right ankle and foot and one plus pitting edema (indentation of 2 millimeters) in left ankle and foot. RN-C stated R7 had refused to wear support stockings in the past, however indicated R7 should have other interventions in place to manage and monitor the edema, confirming there was nothing in place at this time.

During interview on 8/10/18, at 2:48 p.m. the director of nursing (DON) confirmed R7's lower extremity edema should be monitored with interventions in place to control it.

SEE F684 FOR ADDITIONAL INFORMATION

Activities of Daily Living (ADLs):

R4 was not given assistance with nail care and shaving. R4's care plan reviewed 8/7/18 indicated the resident required assistance of 1 staff with personal hygiene. The care plan further identified interventions to use if R4 was exhibiting behaviors during cares.

During observation on 8/6/18, at 1:56 p.m. R4

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was noted to have long soiled fingernails and long white hair on her chin.

During observation of morning cares on 8/8/18, at 7:16 a.m., R4 continued to have long nails and chin hair. Nursing assistant (NA)-D looked at R4's long dirty fingernails and stated "oh I wish you'd let us trim your nails". Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no attempt to trim nails, shave chin hair or provide oral care.

During observation on 8/08/18, at 2:43 p.m. R4 was observed in the dining room feeding herself an apple turnover with long dirty nails and long white chin hair.

During observation of morning cares on 8/9/18, at 10:19 a.m., R4 continued to have long nails and chin hair. NA-E stated R4 was in a "wonderful mood" and it was a good time to complete cares. Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no offer of shaving, oral cares or nail care.

During interview on 8/9/18, at 1:23 p.m. NA-D and NA-E confirmed they had not offered oral care, shaving, or nail trimming to R4 with morning cares. NA-D further indicated R4 required assistance with these grooming tasks and confirmed R4 had long fingernails and chin hair.

During interview on 8/9/18, at 2:09 p.m. registered nurse (RN)-C confirmed R4 had long fingernails and chin hair which she described as a "goatee". RN-C indicated R4 has behaviors and will refuse cares, however oral care and shaving should be offered daily before breakfast, and nails trimmed and cleaned when R4 allows.

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On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to shave, trim nails and provide oral cares prior to breakfast. The DON further stated she had gotten R4 a new razor about one week prior and would expect staff to reapproach or complete tasks when she was cooperative if refused.

R54 was not provided assistance with oral care. R54's care plan last revised 7/4/18, identified a self care performance deficit related to left hemiparesis and inability to independently bathe, dress, or groom. The care plan further identified R54 with several natural teeth broken off. Interventions included staff assistance with personal hygiene and assist to brush teeth after set up twice daily.

R54's ADL care area assessment (CAA) dated 11/7/17 indicated extensive to total assist was needed for all ADL's due to hemiplegia.

During interview on 8/6/18, at 7:14 p.m. family member- A stated she frequently notices food between R54's teeth and questioned if his teeth were being brushed twice daily.

On 8/8/18, at 7:38 a.m. R54 was sitting in his room in a Broda chair. He indicated his teeth had not been brushed. An oral care basin, including a dry toothbrush was observed in the medicine cabinet above the sink in R54's room.

On 8/8/18, at 9:43 a.m. R54 was observed to be sleeping in his bed. The oral care basin was observed in the same location with a dry toothbrush.

On 8/8/18, at 1:19 p.m. toothbrush remained dry.

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During interview on 8/8/18, at 1:31 p.m. NA-C stated oral cares are completed when getting residents up in the morning. NA-C then confirmed she had not brushed R54's teeth this morning stating she had "forgot".

On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to provide oral cares per plan of care.

R48 was not provided assistance with oral care and eating. R48's care plan dated 7/7/18, indicated the resident had his own teeth and required extensive assistance of one staff with oral cares. Oral cares to be performed BID (twice a day) as he allows.

When interviewed on 8/6/18, at 4:17 p.m. family member (FM)-G stated feeling R48's mouth had seemed quite dirty at times and wondered if staff brushed his teeth.

On 8/9/18, at 8:56 a.m. nursing assistants (NA)-D and NA-H were observed providing morning cares for R48. NA's transferred R48 from the recliner where he slept in the dining area, into his wheelchair (w/c) via a standing lift. NA-H then propelled R48 into the tub room. NA-H and NA-D then transferred R48 via the standing lift onto the toilet. NA-D donned gloves and assisted the resident with washing his face then cleaned his hands and fingernails thoroughly. NA-D then obtained a clean washcloth and towel and washed and dried R48's underarms. R48 was swishing his mouth as if he had food or liquid in it. NA-D asked R48 if he needed to spit and brought a towel up to his mouth but the resident wouldn't spit. NA-D doffed her gloves and obtained toothettes to utilize for oral care but did not

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provide it. NA-D and NA-H then raised resident up and provided pericare; during that time licensed practical nurse (LPN)-A entered the tub room and completed a treatment to R48's bottom after pericare was completed. Once LPN-A completed the treatment, NA's then finished with dressing R48 and transferred him into his w/c. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care.

When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes.

Further review of R48's care plan, last revised 7/24/18, indicated the resident required extensive assist of one staff with eating, and to provide the resident with a calm, quiet setting at meal times with adequate eating time. The care plan further indicated R48 holds liquids/food in mouth and needs reminders to swallow.

On 8/6/18, at 5:50 p.m. R48 was continuously observed seated in his wheelchair (w/c) at the dining room table in Heritage Court during the supper meal; R48's meal was served at that time. At 6:00 p.m. nursing assistant (NA)-G addressed R48 and asked him if he was going to eat, NA-G was assisting another resident at the same table at that time. NA-G showed R48 that his spoon was on his plate; the resident had his hands wrapped up in his clothing protector at that time. At 6:05 p.m., licensed practical nurse (LPN)-C approached R48 to administer medications that were mixed in pudding. With assistance from NA-G, LPN-C eventually was able to administer

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the medications in pudding to the resident as he required verbal prompts and encouragement to swallow the medication as would swish it around in his mouth. The resident was observed to take a drink of his fluids independently but other than the pudding that the medications were mixed in, R48 still had not eaten any of his meal nor offered assistance. The resident continued to drink his fluids independently but would not attempt to eat his food. At 6:28 p.m., NA-K sat next to R48 and assisted the resident with eating his fruit, the resident had already consumed all of his fluids at that time. R48 accepted the offered food and ate approximately 50% of his fruit. At 6:40 p.m., NA-K got up from the table and heated up R48's meal in the microwave then set it on the table in front of R48. NA-K did not offer to assist R48 with eating his meal nor offer more fluids to the resident. At 6:55 p.m., R48 picked up his fork with a bite of potatoes on it, raised it slightly, then set it back down on the plate; R48 was not observed to eat any of his food other than the fruit he had been assisted with.

When interviewed on 8/6/18, at 6:55 p.m. LPN-C stated R48 usually ate good on his own but was not having any of it tonight. LPN-C stated they would check with the resident later to see if he would eat a snack.

On 8/9/18, at 9:49 a.m. R48 was continuously observed during his breakfast meal. LPN-A was observed to prepare and set-up breakfast for R48. LPN-A placed R48's plate in front of him then continued to pass medications in the dining room; LPN-A did not offer to assist R48 with eating. At 9:51 a.m., LPN-A asked R48 if he was going to try his breakfast. The resident didn't respond. LPN-A then asked NA-D to assist R48 with eating. NA-D assisted R48 with eating until

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2 800	Continued From page 42 10:00 a.m. as went to assist another resident; LPN-A was also administering medications to R48 at that time. LPN-A administered R48's medications in pudding then offered the resident a drink. R48 observed to swish the fluid around in his mouth. When NA-D returned to assist R48, LPN-A instructed NA-D to not attempt to feed R48 more at that time as he wasn't swallowing and didn't want the resident to choke. At 10:17 a.m., R48 was observed to place his glass containing his supplement into his oatmeal; LPN-A continued to administer medications and NA-D and NA-H were assisting other residents. At 10:21, a.m., LPN-A approached R48, removed his glass of supplement from the oatmeal, and attempted to assist the resident with eating. LPN-A offered the resident a drink of orange juice which he accepted. LPN-A prompted R48 to try to swallow the juice rather than swishing it around in his mouth. LPN-A then washed his hands and continued to set-up and administer medications. At 10:26 a.m., R48 was observed with his fingers in his oatmeal; the resident continued to swish has food/fluid contents in his mouth. R48 would spit some of it out at times then wiped his mouth with his fingers. At 10:34 a.m., the pastor entered the dining room and greeted the residents stating they were going to have hymn sing. R48 was observed to take drinks of his Kemps supplement during the activity but did not attempt to feed himself. At 10:49 a.m., NA-E (who had come to replace NA-H on the unit at 10:00 a.m.), approached R48 and cleaned the oatmeal off his hands. NA-E asked the resident if he was finished eating and the resident indicated he was. NA-E also asked R48 if he wanted to finish his juice and the resident indicated that he did. When interviewed at that time, NA-E confirmed that sometimes R48 was able to eat independently and sometimes required	2 800		

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assistance.

When interviewed on 8/9/18, at 10:59 a.m. RN-C confirmed R48 required extensive assistance of one staff with meals though sometimes he did refuse to eat. RN-C stated if the resident was resistive to assistance would expect that staff would stop and then reapproach. On subsequent interview on 8/10/18, at 2:41 p.m. RN-C stated the staff on Heritage Court had a lot of people to feed and not enough help.

SEE F677 FOR MORE INFORMATION

Restorative Nursing:

R48 and R39 did not receive restorative nursing services per the plan of care.

R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to dementia, Parkinsonism evidenced by freezing gait and physical weakness. The care plan interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2-3 times a week.

Review of R48's Documentation Survey Reports dated May 2018-August 2018 related to restorative nursing rehab completion indicated the following: May 2018 - one time out of 23 opportunities (5/18/18). June 2018 - 3 times out of 21 opportunities (6/8/18, 6/14/18, 6/19/18). July 3018 - 2 times out of 21 opportunities (7/2/18, 7/31/18). August 2018 - 1 out of 8 opportunities (8/1/18).

When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work

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the floor if someone called in. NA-E further confirmed being pulled from restorative that day.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done.

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2 800	Continued From page 45 During interview with R39 on 8/7/18, at 9:22 a.m. she stated, I supposed to get rehab 3 times a week. I get arm and leg exercises and do the step. I am supposed to have exercises on my band hand too. She further stated I haven't had it at all in August yet. In July I had it 4 times. R39 took me to her computer and pulled up a spread sheet she had made. She had documented on the spread sheet the days in July she received restorative. The days were 2, 5, 24 and 31. She stated a staff member had retired on June 30 and since this occurred it has been really bad. She stated one of the nurses was supposed to be doing it and the nurse is not very good. She stated there is one other girl who is very good but I haven't seen her in awhile. She stated I am supposed to get it Monday, Wednesday and Friday. On 8/7/18, at 11:30 a.m. R39 was observed in the therapy room with aide performing restorative exercises. R39 looked at surveyor, shook her head, shrugged her shoulders and smiled. On 8/9/18, at 2:05 p.m. R39 was asked if she got walked by staff. She laughed and pointed to a June calendar on the back of her door and stated well look at that, that will tell you. Staff had initialed on June 13, 14, 15, 17 and 18th that resdient was walked. She said that's how much I got walked. I was supposed to walk 1-2 time a day. Now they don't walk me at all. They just didn't and I don't know why. When asked if she was able to walk now she stated I was able to before but don't know if I still can. I haven't done it for a lot of days. R39's care plan, last revised 1/5/17, indicated the resident had a need for restorative intervention due to limited physical mobility related to weakness and old CVA (cerebrovascular accident) with right hemiparesis evidenced by	2 800		

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inability to independently transfer and ambulate. Goal: resident will maintain current level of mobility of transferring independently in bathroom using handrail. Interventions included active range of motion (ROM) upper extremity (U/E) left with red T-band, 20 repetitions (reps) times 2, 3 times per week, active ROM lower extremity (L/E) left seated exercises with 3# weight 20 reps 3 times per week, active ROM L/E right seated exercises with 0# weights 10 reps 3 times per week, active ROM NuStep at level 5 10 min 3 times per week, passive ROM to right arm 20 reps as tolerated 3 times per week. The care plan updated 8/2/18, also indicated R39 was unable to ambulate or transfer independently using a total lift for transfers.

Review of R39's nursing notes does not indicate why resident was not walked or had restorative per the care plan. A note written 8/8/18, (after surveyor identified issue) identified that due to changes in resident condition she is no longer able to ambulate or use the NuStep as part of her restorative program. Once she has stabilized an order for skilled therapy to evaluate and treat will be obtained to set up further orders for her restorative program. Resident is not realistic about her abilities but this has been explained to her.

Review of R39's Documentation Survey Reports dated June 2018-August 2018 related to restorative nursing rehab completion indicated the following: Walking 1-2 times per day: May 2018, 2 times (5//10, 5/29) June 2018, 7 times, (6/4, 6/5, 6/11, 6/15, 6/18, 6/19 and 6/28). July 2018, 2 times (7/3, 7/9). 20 days were marked not applicable. August times 2 (8/1 and 8/2 non applicable rest x' d off). Restorative exercises: July 4 days (7/2, 7/5, 7/24, 7/31) 4 refusals.

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August times 2 (8/7, 8/8).

When interviewed on 8/8/18, at 8:00 a.m. physical therapy aide (PTA)-A stated I know that restorative is short so I don't know how much is getting done I think nursing is doing it if they don't have aides

When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day. She stated she gets upper and lower exercises and the NuStep. She stated it depends on who is doing it if she refuses. She has never refused for me. You have to try to get her before bible study because she always goes to that if you get her from 9:15 to 9:30 it's fine. She stated I see her M-Tu-Th if I don't get pulled to the floor. We had someone retire at the end of June so it doesn't always get done.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.

When interviewed on 08/10/18, at 12:14 p.m. nursing assistant (NA)-L stated R39 walked with 2 assist 20-30 feet. She stated it's been a couple weeks I think. The aides do the walking as well as restorative.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H

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2 800	Continued From page 48 stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff. PT-H stated R39 had a program a while back and was transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers. When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative sheets. It should be refused or not available. She stated I don't know why she wasn't walked in July. She stated she just started with a change in condition this week. I don't know why she didn't get it in June. We had someone retire end of June so that could be why it didn't get done July and August.	2 800		

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SEE F676 FOR ADDITIONAL INFORMATION

RESIDENT/FAMILY CONCERNS WITH LACK OF STAFFING

R48's quarterly MDS dated 6/29/18, identified R48 had severe cognitive impairment and required extensive assistance to complete his ADLs. When interviewed on 8/6/18, at 4:07 p.m. family member (FM)-G stated sometimes it takes a while for R48 to get help to get to the bathroom; staff had told her he usually gets there on time prior to being incontinent. FM-G further stated feeling R48's mouth had seemed quite dirty at times and wondered if staff brushed his teeth.

R39's quarterly MDS dated 6/15/18, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further indicated R39 required extensive assistance with toileting. When interviewed on 8/7/18, at 9:15 a.m. R39 stated last night they were short of help. They have to have 4 (NAs) working but a lot of times they don't; we have to wait. R39 further stated having to wait an hour before, and had been incontinent due to waiting so long.

R16's Quarterly MDS assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. When interviewed on 8/6/18, at 6:44 p.m. R16 stated having to use the bed pan at night because it takes two people to use those machines (lifts) and I had to use the machines. R16 further stated the bed pan would

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go over and then I would end up with a wet nightgown; they said there is no other way you just have to put up with it.

R58's admission MDS dated 7/9/18, identified a BIMS score of 8 indicating moderate cognitive impairment. The MDS further indicated the resident required extensive assistance with transfer and toilet use. When interviewed on 8/6/18, at 4:01 p.m. R58 stated having to wait up to an hour for assistance with toileting. R58 further stated having had accidents in my pants, "It just happened last night. I was laying in poop for over 20 minutes."

STAFF CONCERNS WITH LACK OF STAFFING

When interviewed on 8/6/18, at 2:34 p.m.trained medication aide (TMA)-A stated they usually staffed Heritage Court with 1 nurse or TMA and 2 NAs. TMA-A stated that was usually a good resident to staff ratio though in the evening when the resident's sundown it can get really wild. TMA stated she had worked an evening shift last week and was really glad she had 2 NA's on as it doesn't always work out that way.

When interviewed on 8/9/18, at 10:29 a.m. NA-H stated she was supposed to be done at 10:00 a.m. this morning and is just getting ready to leave. NA-H stated they usually have a night aide that stays and helps them get people up but she had to leave for her other job at 6:30 a.m. so they ran behind today. NA-H stated sometimes they could use more help in Heritage Court. NA-H further stated feeling that there should always be a staff person in the main dining room area where most residents gather when out of their rooms; sometimes that isn't possible when the staff need to be in rooms to assist other residents. NA-H

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then stated, "Yes, we could use more help."

R48 was not provided assistance with eating. When interviewed on 8/9/18, at 10:59 a.m. RN-C confirmed R48 required extensive assistance of one staff with meals though sometimes he did refuse to eat. RN-C stated if the resident was resistive to assistance would expect that staff would stop and then reapproach. On subsequent interview on 8/10/18, at 2:41 p.m. RN-C stated the staff on Heritage Court had a lot of people to feed and not enough help.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A indicated Heritage Court was really no different from any other part of the building as far as staffing. LPN-A stated he floats all over the building and also works in restorative therapy. LPN-A further stated he was pulled from restorative today to work in Heritage Court as the nurse scheduled called in. LPN-A confirmed that when working the day shift on Heritage Court, the TMA or LPN scheduled is responsible for serving the residents their breakfast and further confirmed this did put his medication pass behind. LPN-A further confirmed nurses/TMAs on other units are not responsible for serving the breakfast meal. When asked if the restorative services he was to provide that day for residents were still being completed, LPN-A stated he didn't know.

When interviewed on 8/9/18, at 2:13 p.m. NA-D states sometimes they have enough in Heritage Court but not always; a lot of it depended upon how the residents were doing related to health and behaviors. NA-D stated the night staff NA was supposed to stay until 7:30 a.m. to help get residents up but that doesn't always happen. NA-D further stated there are some night staff

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that refuse to stay until 7:30 a.m. so they only schedule those employees until 6 a.m. NA-D stated today they didn't have a night person stay and it was really difficult to get every one up and fed as the other NA who worked until 10:00 a.m. and was giving baths. NA-D further stated many of the residents are 2 person assist so she had to wait to get assistance with those residents.

When interviewed on 8/10/18, at 10:36 a.m. NA-I stated it depended upon the day but at times it could be very overwhelming in Heritage Court. NA-I stated she usually worked evenings and felt that shift was the worst, especially from 3:00 - 4:30 p.m. as they were many times down to 2 staff during that time. NA-I further stated on the day shift it's very busy when they are getting resident's up in the morning; usually a night shift staff will stay until 7:30 a.m. to help but not always. NA-I stated having one more staff on the unit would definitely help. NA-I also stated they try to always have a staff in the dining area as that is where the majority of the residents gather when awake; occasionally they would leave the area with no staff present but it's a very short time.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing

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2 800	Continued From page 53 services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. During interview on 8/10/18, at 3:34 p.m. the human resources (HR) director stated they had an acuity rate which determines the staffing on each unit. When interviewed on 8/10/18, at 3:42 p.m. the administrator stated the acuity of staff is based on number of residents in the building; where staff was disbursed was based on the acuity of the residents per station. Ideal staffing: Heritage Court- 2 day NAs and one nurse or TMA. Evening the same and nights 1 NA (RN or LPN scheduled at night covers the building). Center - 4 day NAs, 1 nurse, 1 case manager for Center and Heritage Court (400 and 500 wings), Evenings - 4 NAs and a nurse. Nights- 2 NAs. South: Days - 4 NAs, 1 nurse and case manager. Evenings - 4 NA's and 1 nurse. Nights - 1 NA and 1 nurse. The HR director confirmed the restorative aide got pulled a lot to the floor, to complete patient cares vs completing restorative nursing tasks. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving	2 800		

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2 800	Continued From page 54 care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services in a timely manner to ensure pain management was maintained for 1 of 3 residents (R16) who sustained an injury from a fall. R16 suffered harm, severe pain following the injury and was subsequently diagnosed with a fractured ankle; The facility also failed to ensure hospice services were coordinated for 1 of 1 (R41) residents reviewed who was receiving hospice;	2 830	Corrected	9/19/18

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and failed to monitor edema (fluid retention) for 1 of 1 resident (R7) reviewed for edema in feet/ankles.

Findings include:

R16's Admission Record face sheet identified R16 was admitted to the facility with diagnoses including unspecified convulsions, muscle weakness and a history of falling.

R16's Quarterly Minimum Data Set (MDS) assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. R16 was identified as having no pain and no falls since prior assessment 2/23/18.

R16's current care plan, last revised 6/18/18, identified R16 had an actual fall with minor injury R/T (related to) urinary tract infection (UTI) with weakness evidenced by 2 falls on 6/16/18. The goal was identified as resident will resume usual activities without further incident. Interventions included monitor/document/report PRN (as needed) times 72 hours to health care provider for s/s (signs/symptoms) pain, bruises and monitor for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. A care plan problem dated 6/20/18, identified the resident had acute pain/discomfort R/T right ankle fracture with surgical repair.

An Incident Report dated 6/16/18, at 5:40 a.m. indicated staff had gone into R16's room when

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the resident had not put on her call light by 5:30 a.m. as was her usual routine. R16 was found sitting on the floor next to the bathroom door frame with her walker next to her. The Incident Report indicated R16 had reported she didn't know what had happened, but had complained of the left foot being tender to touch, but having no significant swelling compared to the other ankle. R16 was not able to bear any weight after assessing the ankle however, there was no bruising, and she was able to move the ankle back and forth, and up and down.

Review of an Incident Report dated 6/16/18, at 7:25 a.m. indicated R16 had been assist to the bathroom by staff. The report indicated staff had wheeled R16 into the bathroom and R16 had used the grab bar to stand up. The report indicated staff had then moved the wheelchair out of the room so they'd have room to help the resident however, R16 had suddenly slipped to the floor. The report identified the root cause of the fall may have been related to R16's left foot hurting from a fall 2 hours prior. Following the fall, R16 was assisted with the mechanical lift and 2 staff into bed. At the time she was transferred to bed, her pain rating was identified as a 2 (scale of 1-10 with 10 indicating the worst pain).

Nursing notes indicated R16 had a urine specimen obtained per physician order at 7:36 a.m. on 6/16/18 due to cloudy, amber and foul smelling urine.

Additional notes indicated at 7:48 a.m. on 6/16/18, R16 required an ice pack for swelling to the left ankle, which would be provided every 4 hours as needed (PRN), and the notes indicated R16 had complained of pain to her left ankle.

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A nurse's note from 8:09 a.m. 6/16/18, reiterated R16 had fallen twice within 2 hours. R16 was described in the note as "Alert but confused" and had stated, "I laid there since 10 p.m. last night". The nurse's note further indicated the resident was confused because R16 had been observed in her bed at 3:30 a.m. during rounds, and there had been no calling out or screams from her during the night. The nurse documented it was unlikely R16 could have been on the floor all night: "No tears, flat affect, and skin had no reddened areas of pressure...Left ankle was still painful after administration of PRN Tylenol 650 mg (milligrams). Called primary doctor since she is confused, urine is very foul and incontinent of urine times 2 in last two hours. Used mechanical lift both times to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks."

The notes from 6/16/18, 8:13 a.m. indicated after a second fall in 2 hours, staff had phoned the doctor to inform R16 had fallen twice, hurt her left ankle, but had no swelling after 2 hours of initial fall.

6/16/18, 9:06 a.m. Ice pack for swelling to left ankle every 4 hours as needed. Apply to left ankle for swelling PRN (as needed) administration was effective not swollen but still hurts.

6/17/18, 12:02 a.m. Due to not able to bear full weight on left ankle after her fall, now using sit to stand times two assist to use bedside commode. Left ankle not swollen but is painful. Applied ice pack to affected area. Call placed to eLTC (electronic long term care Dr. available via video)

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2 830	Continued From page 58 for an order to medicate with PRN Tylenol. At 12:04 a.m. the note indicated Acetaminophen tablet 650 mg had been given by mouth. The note further indicated R16 had discomfort in her left ankle, rating it a 5 out of 10 on the pain scale. At 12:07 a.m., the documentation indicated R16 had an ice pack placed due to swelling of her left ankle. The note included, "Has ice pack to left ankle, not swollen but is very tender to touch." An eLTC (telemedicine) note from 6/17/18, with electronic signature at 1:00 a.m., included orders for tylenol 325 mg 2 tablets every 4 hours PRN pain. The note included, "Pt (patient) recently sprained her left ankle. She has an order fo rice, but no order for pain medication. See order above (referring to Tylenol order)." The nurse's notes indicated R16 continued to have swelling and pain in her left ankle throughout 6/17/18. At 5:33 a.m., R16 described th pain as an 8 out of 10. At 7:00 a.m., R16 stated the Tylenol was "no help at all." At 4:15 p.m. on 6/17/18, R16 stated, "I don't think I can stand on my left leg." However, when transferred with a sit to stand lift, the resident had put most of her weight on the left leg with no facial grimacing or complaints, and had denied pain but stated the ankle was "a little sore." On 6/17/18 at 9:57 p.m., the notes indicated R16 had complained that her right ankle hurt. A purple bruise was noted on her inner right ankle. The note indicated, "Will continue to monitor." Nursing notes from 6/18/18 at 2:03 a.m., indicated R16 had received Tylenol (acetaminophen) 650 mg and "was gotten up to bathroom (BR), able to bear weight on both legs but says, very painful." Subsequently, notes	2 830		

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indicated ice packs had been applied to both ankles at 2:12 a.m. At 2:16 a.m., a nurse's note included, "Resident states 'I hurt my right ankle and can't stand on my leg.' When resident is placed in the sit to stand lift for a transfer resident is placing most of her weight on that leg with no facial grimace or any C/O (complaints) noted from the resident. Does have discoloration of teh inner right foot. She has full ROM (range of motion) with that foot & ankle. She did fine with standing and bearing weight on both feet. States, 'It's a little sore is all'."

Additional notes included:
6/18/18, 6:58 a.m. Acetaminophen 650 mg given. Pain scale 9. Resident stated no relief to right leg and ankle pain.
6/18/18, 7:30 a.m. Resident complained of severe right leg pain, requesting analgesics.
6/18/18, 8:29 a.m. Pain scale 10. Resident stated no relief from pain.
6/18/18, 11:57 a.m. Acetaminophen 650 mg given. Resident complained of severe right leg and ankle pain.
6/18/18, 1:36 p.m. Acetaminophen 650 mg PRN administration was ineffective. Pain scale 10 resident stated not having any relief.
6/18/18, 11:06 p.m. Acetaminophen 650 mg followup. Ineffective pain scale 5 still hurting badly.
6/19/18, 12:03 a.m. Very painful when assessing right foot which now, is bruised entirely around the ankle and top of foot is swollen more than last two days. Rather than bear weight on it, will use bed pan tonight. Will get X-ray tomorrow.
6/19/18, 5:09 a.m. Has been using the bed pan to void tonight since she is having so much pain in both feet. Now total lift of mechanical lift with 2 assist to raise up off the bed to change soiled chux. Resident will not turn, insists she's in too

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2 830	Continued From page 60 much pain to move. Medicated with PRN Tylenol (Acetaminophen) 650 mg for severe discomfort. 6/19/18, 5:10 a.m. Pain is so extreme that the resident needs to be raised in bed using mechanical lift. Noted a bruise on under side of left breast. 6/19/18, 6:39 a.m. Had a whirlpool bath. Two assist out of bed with sit to stand lift. Right foot is swollen +2 and bruised Did have a lot of pain when transferred from bed to wheelchair. 6/19/18, 6:39 a.m. Acetaminophen 650 mg was ineffective. Pain scale 8. Resident continues to rate pain severe. On 6/19/18 at 9:17 a.m., the facility sent a facsimile (fax) to the physician questioning whether R16 should have an X-ray of her right foot related to swelling, bruising and pain following her falls on 6/16/18. A 2:41 p.m., the physician's faxed response indicated approval to get an X-ray of R16's right foot/ankle. The family was called and updated, and informed an X-ray had been scheduled for 6/20/18 at 11:00 a.m. 6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain. 6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief. 6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair. 6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resident complained of moderate pain in right ankle. Requesting analgesics. 6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5. 6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8. 6/21/18, 8:15 a.m. To hospital for surgery right ankle.	2 830		

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2 830	Continued From page 61 6/21/18, 7:05 p.m. Returned from hospital where she had right ankle repair about 6:30 p.m. She is in a wheelchair. Right foot is splinted and wrapped with ace. Rates pain at 8 of 10. Will medicate when meds arrive. An order from eLTC dated 6/17/18, at 1:00 a.m. identified nurse called requesting order for Tylenol for pain. Patient recently sprained her left ankle, had an order for ice but no order for pain medication. At this time Acetaminophen 325 mg two tablets every 4 hours PRN pain was ordered. The record further indicated a fax had been sent to the MD on 6/16/18, at 5:40 a.m. identifying R16 had been found on the floor after walking to the bathroom with a 4 wheeled walker. The fax indicated R16's ROM (range of motion) to left ankle was painful when putting pressure on foot, but there was no swelling. The fax included, "Does not want to stand on left ankle. No bruising." A return fax from the physician was received 6/18/18, at 12:20 p.m. with physician comment, "I was called about this, I assume all is now well. Yes?" No reply was sent to the physician regarding pain and swelling of right ankle. Review of a pain assessment dated 6/18/18, indicated R16 had pain associated with a diagnosis or condition and identified non-pharmacological interventions to include: ice and rest. The assessment also identified the current medication regimen of PRN Tylenol 650 mg and ice PRN was not working. X-Ray result findings of the right ankle dated 6/20/18 indicated: "Findings: "... a Weber type B distal fibular fracture. Probable medial malleolar fracture. Allowing for osteopenia no acute	2 830		

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displaced facture is seen in teh mid to forefoot. of the right ankle."

During interview with the director of nursing (DON) on 8/9/18, at 10:24 a.m. she stated staff should have been in touch with the doctor in a more timely way rather than faxing. The DON verified no follow up was done to ensure the pain medication was effective, or to notify the doctor of the resident's pain status and change in ADL ability due to the pain. The DON stated with complaints of pain something obviously changed since there was swelling and bruising. In addition, the DON confirmed R16 had been independent in her room with walking prior to the falls but after the falls required transfer assistance with a mechanical lift and 2 assist. As such, the DON said the doctor should have been notified after his fax had been recieved 6/18/18 to notify him of R16's increased pain, swelling and change in condition. The DON stated the nurse should have called the physician about getting an X-ray instead of faxing on 6/19, and should have tried to get the resident in for the X-ray sooner. She stated they saw bruising on the 17th, first on the left then on the right which should have been addressed and added, "we have pain meds in the E-kit (emergency kit) we could have used to make her more comfortable since the Tylenol was obviously not working for pain control."

During interview with R16's doctor on 8/14/18, at 3:22 p.m. he stated he should have been notified of the increased pain and swelling of the ankle. He stated although he was notified by fax of the fall the morning it happened, he did not see the fax until Monday morning 6/18/18 at which time he'd responded back and asked if everything was "ok". He stated, "I did not hear anything back from them until they asked for an X-ray on the

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19th."

COORDINATION OF HOSPICE SERVICES:

The facility failed to coordinate hospice services for R41.

R41's medical director had signed a certification/recertification of hospice services on 6/7/18. The form indicated hospice services had originally been initiated 3/18/18, due to R41's diagnosis of senile degeneration of the brain.

R41's significant change MDS dated 3/23/18, indicated R41 had severely impaired cognition, and total dependence with all activities of daily living (ADLs). The MDS also indicated R41 was receiving hospice services.

R41's care plan revised 4/3/18, indicated R41 had a terminal prognosis related to end stage dementia and was receiving hospice care. Interventions included: assess resident and family coping skills, contact hospice staff for support as needed, work with nursing staff to provide maximum comfort for the resident.

A clip board with numerous papers attached was observed at the nurses station. Under numerous papers was a paper that said ATTENTION FACILITY STAFF! "[R41] is under the care of (name of hospice)." The team was identified as nurse, social worker and chaplain. No aide or volunteer was identified. A second page was located on the clip board under that page: "(name of hospice) nurse-weekly visits on Monday, Aide-provides AM (morning) ADL cares Monday thru Friday. Chaplain/SS (social service) Thurs/Fri (Thursday/Friday). No patient name was identified on the second page. The hospice agency plan of

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care provided by the facility also failied to include a hospice visit schedule on it.

During observation on 8/8/18, at 7:05 a.m. a hospice aide was present giving R41 a bath. At 7:43 a.m. R41 was sitting at the breakfast table being fed by a facility staff member. The staff stated the hospice aide left after giving R41 her bath.

During interview on 8/8/18, at 8:13 a.m. nursing assistant (NA)-D stated, "we don't know what they [hospice staff] are going to do when they come. For instance, today they couldn't feed her because they had to go do something else. Sometimes they give her a bath and feed her, sometimes they just feed her. We never know. We don't know days or times they will come either. Sometimes they tell us, sometimes they don't. I think they are supposed to come 3 days a week or something, but they maybe only come two. We never know what time, sometimes it's 6 a.m. when they are supposed to be her at 8. Other times, they've come at like 4 in the afternoon too."

During interview on 8/8/18, at 8:30 a.m. NA-F stated, "you never know around here when they will come. Sometimes they come and then they have to leave because they have to go somewhere else so they don't do everything they are supposed to. If they can't make it they don't tell us they just come another day."

During interview on 8/8/18, at 9:00 a.m. RN-C stated, "There is a calendar at the desk. The aide comes every morning Monday through Friday between 6 and 8 a.m. They have a chaplain and a social worker that come in the later part of the week. The nurse comes on Tuesday, she was

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here yesterday. She [R41] has a volunteer that comes a lot. If they can't make it they don't tell us they just come another day. My hospice people are stable so I'm not concerned about it. If they do let the nurse know they aren't coming then the aides should be told that too."

During interview on 8/8/18 at 9:28 a.m., licensed practical nurse (LPN)-B stated she did not know where the calendar for hospice was located in order to know when hospice was coming. RN-B came onto the unit during the interview and stated, "The calendar is under the clip board".

During observation on 8/9/18, at 7:47 a.m. a hospice aide (HA)-A was observed in the dining room feeding R41. At that time, HA-A stated, "We are here 5 days per week for [R41]. I come at 5:30 a.m. because I have another patient here also. We have 5 different aides and we all have different schedules. It depends on where the clients are, and who has them, as to what time they come. If I do morning cares then I don't feed, and if I don't do morning care then I feed her breakfast, play music, curl her hair. Normally her bath is done so then I feed her. Yesterday I had to go because we were short, someone called in so we had to split visits up so I had to go. I don't talk to the staff really unless something is out of the ordinary. I just come in and go directly to her room to help her. If I need to tell them [staff] something I will, such as if something is different or out of the ordinary.

During interview with the DON on 8/9/18, at 12:47 p.m. she stated, "The hospice should give us a schedule. We need to tell them we don't know when their people are coming. That is not good communication for continuity of care."

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EDEMA MONITORING

R7's diagnosis report dated 8/10/18, included diagnoses of edema, macular degeneration (an eye disease that causes vision loss), and dementia.

R7's quarterly Minimum Data Set (MDS) assessment dated 5/4/18, identified R7 as having a Brief Interview of Mental Status (BIMS) of "8" indicating a moderately impaired cognition. The MDS further indicated R7 required assistance with bed mobility, transfers, dressing, toilet use, hygiene, and bathing.

R7's care plan reviewed 5/17/18, indicated R7 required assistance with activity of daily living (ADL's) related to impaired vision, muscle weakness, and impaired cognition. The care plan did not address the residents bilateral edema in her feet/ankles.

Review of R7's current physican orders dated 6/12/18, included Lasix (a medication to reduce extra fluid in the body) 80 milligram (MG) daily for edema.

During observation on 8/8/18, at 12:50 p.m., R7 was observed to have bilateral edema in her feet and ankles. The resident was sitting in a recliner chair in her room with her feet resting on the floor. The resident had velcro closing shoes and grippy socks on, however there was visible indentation to R7's ankles from the grippy socks. The right ankle also had a reddened appearance.

During observation on 8/9/18, at 8:46 a.m. nursing assistant (NA)-C transferred R7 into a recliner chair. R7 was wearing socks and shoes, however visible bilateral edema to ankles was

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GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET WINDOM, MN 56101**

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2 830	Continued From page 67	2 830		

noted, and her feet remained on the floor when NA-C left the room.

During interview on 8/8/18, at 10:04 a.m. NA-C confirmed R7 had edematous ankles. NA-C further stated there were no specific interventions for the edema but indicated R7 would elevate her feet if she wanted to.

During interview on 8/8/18, at 1:09 p.m. registered nurse (RN)-B indicated R7 had long standing edema to her lower extremities. RN-B confirmed there was no formal monitoring in place for the edema.

During observation and interview on 8/9/18, at 2:22 p.m., R7 was sitting in her recliner chair with her feet on the ground. RN-C assessed R7's lower extremities stating they were cool and dry. RN-C further verified right lower extremity had a redness present but no warmth or discomfort noted from R7. RN-C identified R7 had two plus pitting edema (swelling that is significant enough to cause an indentation of 3-4 millimeters deep in the skin when depressed with a finger) in right ankle and foot and one plus pitting edema (indentation of 2 millimeters) in left ankle and foot. RN-C stated R7 had refused to wear support stockings in the past, however indicated R7 should have other interventions in place to manage and monitor the edema, confirming there was nothing in place at this time.

During interview on 8/10/18, at 2:48 p.m. the director of nursing (DON) confirmed R7's lower extremity edema should be monitored with interventions in place to control it.

A facility policy titled Care Plan revised 11/16, indicated each resident will have an

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2 830	Continued From page 68 individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate all staff on the policies and procedures to ensure that all resident's health issues are properly monitored and provided. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		9/19/18

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2 900	Continued From page 69 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure relieving interventions for 1 of 1 resident (R48) with two current facility acquired stage 2 pressure ulcers. This deficient practice resulted in actual harm for R48 when one stage 2 pressure ulcer worsened and a new stage 2 pressure ulcer developed. Findings include: R48's Admission Record Face Sheet, indicated R48 had been admitted to the facility on 1/5/18, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18, indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The MDS further indicated R48 was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, and utilized a pressure relieving device in bed and chair. R48's current care plan, last revised 7/24/18, included: The resident has potential for pressure ulcer development R/T (related to) needs assist with mobility and frequent bladder incontinence.	2 900	Corrected	

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2 900	Continued From page 70	2 900		

The interventions included: Pressure reduction mattress and cushion in w/c (wheelchair). Notify nurse immediately of any new areas of skin breakdown; redness, blisters, bruises, discoloration, etc. noted during bath or daily care.

R48's Mobilization Support Data Collection Tool dated 6/28/18, indicated the resident had enough torso strength to maintain an upright, seated position, used a sit-to-stand lift with assist of two staff when transferring between surfaces, and required assist of two staff with a walker for ambulation. The data did not indicate what support R48 needed to position up in bed, turn in bed from side-to-side, to move from lying to sitting on the edge of bed, or to move from a seated position on the side of the bed to a lying or reclined position in bed. The data indicated: Does not sleep in a bed.

R48's quarterly Braden Scale for Predicting Pressure Sore Risk dated 6/28/18 was scored as 13, indicating R48 was at moderate risk for skin breakdown. In addition, R48's recent Skin Observation form dated 8/5/18, indicated: no skin conditions observed.

On 8/8/18, R48 was continuously observed from 7:15 a.m. until 9:38 a.m. lying in a recliner in the dining area. Staff were assisting other residents in and out of the dining room and providing breakfast during that time. R48 had one leg on the footrest of the recliner with the other leg hanging down with one shoe off and one shoe on. R48 would move his legs periodically and would make moaning/humming type sounds. At 9:38 a.m., nursing assistant (NA)-D approached R48 and asked if he was ready to get up; the resident responded he was. NA-D and NA-F pivot transferred R48 into his wheelchair (w/c) which

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2 900	Continued From page 71 had a pressure reducing waffle air cushion on the seat. The resident's recliner did not have a pressure reducing cushion on the seat. NA-D then propelled R48 into the tub room to assist him to the toilet. NA-D indicated the night aide (NA-J) had completed R48's morning cares earlier, and had assisted R48 to the toilet around 6:00 a.m. (approximately 3 1/2 hours earlier). NA-D and NA-F were observed to transfer R48 onto the toilet. When R48 was finished on the toilet, NA-D and NA-F stood the resident up to provide peri-care. R48's bottom was observed to have 2 small open red areas, one on the coccyx and one on the right upper buttock near the crease; the areas were circular and approximately 0.5 centimeters (cm) in diameter. When asked if the areas were new, NA-D stated they were new to her. The NAs then sat the resident back down onto the toilet and alerted the nurse to come into the tub room to observe the resident's bottom. Licensed practical nurse (LPN)-B entered the tub room and confirmed R48 had 2 open areas on his bottom. LPN-B stated the areas were new to her but that she would have to research the resident's medical record to make sure they had not been there prior to today. LPN-B then instructed the NA's to feed the resident breakfast first prior to providing treatment or measuring the open areas. When interviewed immediately following the observation, NA-D confirmed R48 always slept in the recliner in the dining area. NA-D stated when the resident first came to the facility they would attempt to have him sleep in the recliner in his room as the resident had slept in a recliner at home however, NA-D stated R48 would crawl out of the recliner in his room and come out to the recliner in the dining area to sleep. NA-D stated per R48's preference, they continued to have him sleep in the recliner in the dining area.	2 900		

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2 900		2 900		

Continued From page 72

When interviewed on 8/8/18, at 10:27 a.m. NA-D stated staff try to reposition R48 every 2 hours though sometimes it can be longer. NA-D further stated sometimes the resident was resistive to repositioning, and other days he was up and on the move.

A facsimile (Fax) to R48's physician dated 8/8/18, and sent at 11:34 a.m. indicated: "[R48] has an open area on his coccyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or soiled." A fax response from the physician, dated 8/9/18 at 10:07 a.m., was reviewed with physician approval of this plan.

On 8/8/18, at 1:10 p.m. R48 was observed laying in the recliner in the dining room with his knees bent and eyes closed. When interviewed at that time NA-D confirmed the resident had been transferred into the recliner at approximately 12:50 p.m. NA-D further confirmed LPN-B had not yet measured or done any type of treatment to the open areas on R48's bottom as she was awaiting direction from the registered nurse case manager (RN)-C.

When interviewed on 8/8/18, at 1:57 p.m. LPN-B stated she had applied a hydrocolloid dressing to the open area on R48's coccyx. LPN-B stated the dressing was large enough to cover the smaller superficial reddish areas below the coccyx as well. When asked about the other open area on R48's right upper buttock, LPN-B stated not realizing the resident had more than one open area. LPN-B then stated she would be back to work tomorrow morning and could look at it then. LPN-B confirmed she had not measured the open area on R48's coccyx as staff was having a difficult time keeping the resident

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2 900	Continued From page 73 standing during the treatment. LPN-B stated the open area on the coccyx was approximately 0.5 cm round in diameter. LPN-B confirmed R48 had never utilized a pressure reducing cushion when in the recliner. On 8/9/18, at 8:56 a.m. NA-H and NA-D were observed getting R48 up out of his recliner to perform morning cares. The NA's utilized a standing lift (a mechancical lift) to transfer R48 into his w/c. R48's w/c had a pressure reducing waffle air cushion on the seat with very little air in the cushion; the recliner did not have a pressure reducing cushion on the seat. R48 was then propelled into the tub room to be toileted and assisted with cares. NA's utilized the standing lift to transfer the resident onto the toilet, NA-H removed R48's brief, which was soiled with bowel movement. NA-D asked NA-H if there was a duoderm dressing on the resident's bottom and NA-H informed her there was not. After assisting R48 with washing up and changing clothes for the day, NA-D and NA-H then raised the resident up to a standing position with the lift and provided peri-care. R48 hollered out "Ow!" while his bottom was being cleansed. R48's bottom was observed; there was no dressing covering the resident's coccyx. R48 had two open areas on the coccyx, an upper open area on the coccyx was new since the observation on 8/8/18. The lower open area on the coccyx was larger with white slough covering the wound bed. The area on the right upper buttock near the crease had decreased in size, was reddened and appeared to be closed, there was another small reddened area next to it. NA's put the call light on to alert the nurse. LPN-A entered the room and measured the open area's on R48's coccyx. The new upper area on the coccyx measured 1.0 cm and was circular, the lower open area measured	2 900		

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2 900	Continued From page 74 1.8 cm x (by) 1.0 cm. LPN-A also identified the small reddened areas on R48's right buttock though felt they were scratches. LPN-A applied skin prep to R48's coccyx then covered the open areas with a hydrocolloid dressing. NA-H then finished dressing R48 and transported him to the dining room for breakfast. When interviewed on 8/9/18, at 10:49 a.m. NA-E stated R48 was to be repositioned every 2 hours just like all the other residents on the unit. When interviewed on 8/9/18, at 10:55 a.m. LPN-A stated he was told when coming on duty today that RN-C wanted him to take a good look at R48's bottom as it had been reported there was an open area. LPN-A stated other than that there were no new interventions to inform RN-C of, or any further reports of what he'd observed, but that she'd (RN-C) take it from there. When interviewed on 8/9/18, at 10:59 a.m. RN-C stated LPN-B had reported R48 had an open area on the coccyx, was unable to measure the area due to the resident becoming uncooperative though was able to cover the area with a duoderm dressing. RN-C stated she had updated R48's care plan indicating the resident was to be repositioned once awake, before and after meals, for the 3:00 p.m. activity in the afternoon, and at HS (bedtime). RN-C confirmed that would be approximately every 2 hours, as R48 allowed. RN-C stated in the morning staff usually wait until R48 has his eyes open and is ready to get up before initiating cares. RN-C further stated staff do not push it and if R48 was resistive, they let him sleep. RN-C also stated they'd be implementing R48's pressure reducing cushion to be utilized when the resident was in the recliner as well as the w/c. RN-C stated prior	2 900		

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2 900	Continued From page 75	2 900		

to this a pressure reducing cushion had not been utilized in R48's recliner as they had not thought it necessary as the recliner cushion was soft. RN-C confirmed the pressure reducing cushion should have been utilized in R48's recliner last night and was not sure why it was not. RN-C further confirmed a new dressing should have been applied when R48's previous dressing had fallen off. RN-C stated staff should be monitoring for when the pressure reducing air cushions were deflating and/or needed more air. RN-C stated LPN-A was usually the one to do this as he also worked as a restorative therapy nurse.

When interviewed on 8/9/18, at 1:48 p.m. LPN-A confirmed R48's pressure reducing waffle air cushion was on the low side and definitely needed more air in it. LPN-A stated it was nursing's responsibility to monitor the cushions and make sure they were inflated adequately. LPN-A also stated when the next shift came on at 2:30 p.m. he would have them take the cushion down to therapy to be inflated and would also have staff pick up an extra cushion to keep in the resident's recliner.

Review of the Wound Data Collection dated 8/9/18 by LPN-A identified R48's open areas on the coccyx as moisture associated wounds. When interviewed on 8/10/18, at approximately 10:00 a.m. RN-C confirmed she had not yet visualized R48's open areas on the coccyx and could not say for sure if they were moisture associated or pressure wounds. RN-C further confirmed an RN had not assessed R48's open areas.

During observation on 8/10/18, at 10:38 a.m. RN-C and the director of nursing (DON) confirmed R48 had two stage 2 pressure ulcers

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2 900	Continued From page 76	2 900		

on his coccyx and a small 0.5 cm open area on the inner right buttock.

When interviewed on 8/10/18, at 10:54 a.m. the DON provided documentation of the process staff were to follow when a new skin issue was discovered. The DON stated she would expect staff to notify the RN case manager right away and to fax the physician of the skin issue. The DON stated the RN case manager should evaluate the area as soon as she could to assess and to provide the appropriate treatment and interventions. When the DON reviewed R48's Mobilization Support Data Collection Tool dated 6/28/18, she stated the tool did not fully apply to R48 as he did not sleep in bed and was on his seat much of the time therefore should have been looked at a little differently in terms of positioning. The DON also confirmed a Positioning Assessment and Evaluation had not been completed for R48 to determine an individualized repositioning schedule, and added when R48 stopped utilizing his bed, the care plan should have been updated, and she would have expected a pressure reducing cushion to be utilized in the recliner. The DON stated with repositioning, she would need to see how well R48 slept and what that pattern looked like and go from there. She stated she would've started with every hour and a half to 2 hours for a repositioning schedule. As far as how often to reposition at night if the resident was sleeping would depend upon if he had a good cushion and had pressure mapping completed by physical therapy but confirmed that had not yet been completed for R42. DON confirmed staff should be monitoring for the appropriate amount of air in the cushion R48 was utilizing. DON confirmed an RN should have completed an assessment on the wound when first identified. DON stated

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2 900	Continued From page 77 when there are new interventions for residents' it will go on the care plan and it will come out with a "k" and that will transfer to the kardex so the NA's can see them on the kiosk - there was also a 24 communication written at the station for staff as well. DON stated the NA's should have known to utilize the cushion in his recliner once implemented into the care plan. The procedure titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements revised 4/16 included: 6. Residents who are unable to reposition themselves independently, as indicated on the Mobilization Support Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning schedule. 7. If a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment UDA (i.e., for a pressure ulcer, record the stage). The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection UDA. Skin tears and bruises are not intended to be recorded on this form. SUGGESTED METHOD OF CORRECTION:	2 900		

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2 900	Continued From page 78 The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by:	2 915		9/19/18

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2 915	Continued From page 79 Based on interview and document review the facility failed to provide restorative nursing services for 1 of 3 residents (R48) reviewed for activities of daily living (ADL's) and 1 of 1 resident (R39) reviewed for position mobility. R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to dementia, Parkinsonism evidenced by freezing gait and physical weakness. The care plan interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2-3 times a week. Review of R48's Documentation Survey Reports dated May 2018-August 2018 related to restorative nursing rehab completion indicated the following: May 2018 - one time out of 23 opportunities (5/18/18). June 2018 - 3 times out of 21 opportunities (6/8/18, 6/14/18, 6/19/18). July 3018 - 2 times out of 21 opportunities (7/2/18, 7/31/18). August 2018 - 1 out of 8 opportunities (8/1/18). When interviewed on 8/9/18, at 1:11 p.m. NA-E	2 915	Corrected	

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confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not

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getting done.

R39

R39's Admission Record dated 8/10/18, identified R39 was admitted to the facility with diagnoses including: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, dorsalgia, muscle weakness and chronic obstructive pulmonary disease.

During interview with R39 on 8/7/18, at 9:22 a.m. she stated, I'm supposed to get rehab 3 times a week. I get arm and leg exercises and do the step. I am supposed to have exercises on my band hand too. She further stated I haven't had it at all in August yet. In July I had it 4 times. R39 took me to her computer and pulled up a spread sheet she had made. She had documented on the spread sheet the days in July she received restorative. The days were 2, 5, 24 and 31. She stated a staff member had retired on June 30 and since this occurred it has been really bad. She stated one of the nurses was supposed to be doing it and the nurse is not very good. She stated there is one other girl who is very good but I haven't seen her in awhile. She stated I am supposed to get it Monday, Wednesday and Friday. On 8/7/18, at 11:30 a.m. R39 was observed in the therapy room with aide performing restorative exercises. R39 looked at surveyor, shook her head, shrugged her shoulders and smiled. On 8/9/18, at 2:05 p.m. R39 was asked if she got walked by staff. She laughed and pointed to a June calendar on the back of her door and stated well look at that, that will tell you. Staff had initialed on June 13, 14, 15, 17 and 18th that resdient was walked. She said that's how much I got walked. I was supposed to walk 1-2 time a day. Now they don't walk me at

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all. They just didn't and I don't know why. When asked if she was able to walk now she stated I was able to before but don't know if I still can. I haven't done it for a lot of days.

R39's quarterly MDS dated 6/15/18, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS also identified a functional limitation in range of motion with impairment on one side, limited assistance of two persons to walk in corridor, walking in room occurred only one or two times with two person assistance, extensive assistance of one person with transfers and bed mobility and supervision of one person with locomotion on and off the unit. R39's quarterly MDS dated 3/23/18, identified R39 required limited assistance of one person with walking in room and in corridor.

R39's care plan, last revised 1/5/17, indicated the resident had a need for restorative intervention due to limited physical mobility related to weakness and old CVA (cerebrovascular accident) with right hemiparesis evidenced by inability to independently transfer and ambulate. Goal: resident will maintain current level of mobility of transferring independently in bathroom using handrail. Interventions included active range of motion (ROM) upper extremity (U/E) left with red T-band, 20 repetitions (reps) times 2, 3 times per week, active ROM lower extremity (L/E) left seated exercises with 3# weight 20 reps 3 times per week, active ROM L/E right seated exercises with 0# weights 10 reps 3 times per week, active ROM Nustep at level 5 10 min 3 times per week, passive ROM to right arm 20 reps as tolerated 3 times per week. The care plan updated 8/2/18, also indicated R39 was unable to ambulate or transfer independently using a total lift for transfers.

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Review of R39's nursing notes does not indicate why resident was not walked or had restorative per the care plan. A note written 8/8/18, (after surveyor identified issue) identified that due to changes in resident condition she is no longer able to ambulate or use the Nustep as part of her restorative program. Once she has stabilized an order for skilled therapy to evaluate and treat will be obtained to set up further orders for her restorative program. Resident is not realistic about her abilities but this has been explained to her.

Review of R39's Documentation Survey Reports dated June 2018-August 2018 related to restorative nursing rehab completion indicated the following: Walking 1-2 times per day: May 2018, 2 times (5//10, 5/29) June 2018, 7 times, (6/4, 6/5, 6/11, 6/15, 6/18, 6/19 and 6/28). July 2018, 2 times (7/3, 7/9). 20 days were marked not applicable. August times 2 (8/1 and 8/2 non applicable rest checked off). Restorative exercises: July 4 days (7/2, 7/5, 7/24, 7/31) 4 refusals. August times 2 (8/7, 8/8).

When interviewed on 8/8/18, at 8:00 a.m. physical therapy aide (PTA)-A stated she is aware that restorative is short staffed and did not know how much is getting done. PT-A further indicated she thought nursing was completing it if they didn't have aides.

When interviewed on 8/9/18, at 1:11 p.m. NA-E confirmed being pulled from restorative to work the floor if someone called in. NA-E further confirmed being pulled from restorative that day. She stated R39 gets upper and lower exercises, the Nustep, and indicated R39 had never refused restorative from her, but it depended on what staff

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was working it if she refused. NA-E stated it is best to try approaching R39 before bible study, because she always goes to that. NA-E further explained she sees R39 on Monday,Tuesday, and Thursdays if she isn't pulled to the floor, and indicated a staff member had retired at the end of June so doesn't always get done.

When interviewed on 8/9/18, at 2:08 p.m. LPN-A confirmed being pulled from restorative nursing services to the Heritage Court unit due to a staff calling in. When asked if the restorative nursing duties he was scheduled to complete would be provided by another staff in his absence LPN-A stated he didn't know.

When interviewed on 08/10/18, at 12:14 p.m. nursing assistant (NA)-L stated R39 walked with 2 assist 20-30 feet. NA-L thought it had been a couple weeks, and indicated the nursing assistants do the walking as well as restorative.

When interviewed on 8/10/18, at 03:07 p.m. the physical therapist (PT)-H stated LPN-A completed the majority of the restorative nursing rehab therapy and NA-E also had been trained. PT-H stated when a resident was discharged from therapy a restorative plan was then put into place. PT-H confirmed it was nursing's responsibility to assure the restorative plan was put into place and completed by qualified nursing staff. PT-H stated R39 had a program a while back and was transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers.

When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human

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services (HR) director was in charge of staffing. DON stated the restorative nursing staff is scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R48's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative sheets. It should be refused or not available. She stated I don't know why she wasn't walked in July. She stated she just started with a change in condition this week. I don't know why she didn't get it in June. We had someone retire end of June so that could be why it didn't get done July and August.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could revise policies and procedures for documentation and implementation of ambulation and restorative programs and educate staff related to the changes. The DON or designee could audit resident ambulation and restorative programs for ongoing compliance and report results to the

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2 915	Continued From page 86 quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care, shaving, assistance with eating, and oral care was provided for 2 of 3 residents (R4, R48) reviewed for activities of daily living and failed to provide oral care for 1 of 2 resident (R54) reviewed for dental, who was dependent upon staff for assistance with grooming. Findings include: R4's quarterly Minimum Data Set (MDS) assessment dated 7/27/18, identified R4 as having severely impaired cognition per staff assessment. The MDS further identified R4 required extensive assistance with bed mobility, transfers, dressing, toilet use, bathing, personal hygiene, and exhibited physical behavioral symptoms toward others and rejected care. R4's care plan reviewed 8/7/18 indicated the	2 920	Corrected	9/19/18

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resident required assistance of 1 staff with personal hygiene. The care plan further identified interventions to use if R4 was exhibiting behaviors during cares.

During observation on 8/6/18, at 1:56 p.m. R4 was noted to have long soiled fingernails and long white hair on her chin.

During observation of morning cares on 8/8/18, at 7:16 a.m., R4 continued to have long nails and chin hair. Nursing assistant (NA)-D looked at R4's long dirty fingernails and stated "oh I wish you'd let us trim your nails". Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no attempt to trim nails, shave chin hair or provide oral care.

During observation on 8/08/18, at 2:43 p.m. R4 was observed in the dining room feeding herself an apple turnover with long dirty nails and long white chin hair.

During observation of morning cares on 8/9/18, at 10:19 a.m., R4 continued to have long nails and chin hair. NA-E stated R4 was in a "wonderful mood" and it was a good time to complete cares. Though R4 was pleasant and cooperative with transfers, dressing and toileting, there was no offer of shaving, oral cares or nail care.

During interview on 8/9/18, at 1:23 p.m. NA-D and NA-E confirmed they had not offered oral care, shaving, or nail trimming to R4 with morning cares. NA-D further indicated R4 required assistance with these grooming tasks and confirmed R4 had long fingernails and chin hair.

During interview on 8/9/18, at 2:09 p.m. registered nurse (RN)-C confirmed R4 had long

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fingernails and chin hair which she described as a "goatee". RN-C indicated R4 has behaviors and will refuse cares, however oral care and shaving should be offered daily before breakfast, and nails trimmed and cleaned when R4 allows.

On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to shave, trim nails and provide oral cares prior to breakfast. The DON further stated she had gotten R4 a new razor about one week prior and would expect staff to reapproach or complete tasks when she was cooperative if refused.

A facility policy titled Nail Care last revised 10/17 included: keep nails clean and trimmed to promote well-being.

R54

R54's quarterly MDS assessment dated 7/6/18, identified R54 as having a Brief Interview for Mental Status (BIMS) of 10 indicating moderately impaired cognition. The MDS further identified R54 with a diagnosis of hemiplegia (paralysis of one side of the body) and required extensive assistance with personal hygiene.
R54's care plan last revised 7/4/18, identified a self care performance deficit related to left hemiparesis and inability to independently bathe, dress, or groom. The care plan further identified R54 with several natural teeth broken off. Interventions included staff assistance with personal hygiene and assist to brush teeth after set up twice daily.
R54's ADL care area assessment (CAA) dated 11/7/17 indicated extensive to total assist was needed for all ADL's due to hemiplegia.
During interview on 8/6/18, at 7:14 p.m. family member- A stated she frequently notices food

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2 920	Continued From page 89 between R54's teeth and questioned if his teeth were being brushed twice daily. On 8/8/18, at 7:38 a.m. R54 was sitting in his room in a Broda chair. He indicated his teeth had not been brushed. An oral care basin, including a dry toothbrush was observed in the medicine cabinet above the sink in R54's room. On 8/8/18, at 9:43 a.m. R54 was observed to be sleeping in his bed. The oral care basin was observed in the same location with a dry toothbrush. On 8/8/18, at 1:19 p.m. toothbrush remained dry. During interview on 8/8/18, at 1:31 p.m. NA-C stated oral cares are completed when getting residents up in the morning. NA-C then confirmed she had not brushed R54's teeth this morning stating she had "forgot". On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to provide oral cares per plan of care. A facility policy titled Activities of Daily Living last revised 6/14, included: Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Included in these are the following: 1. General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin , nails and oral care. R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had	2 920		

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severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene.

R48's care plan dated 7/7/18, indicated the resident had his own teeth and required extensive assistance of one staff with oral cares. Oral cares to be performed BID (twice a day) as he allows.

When interviewed on 8/6/18, at 4:17 p.m. family member (FM)-G stated feeling R48's mouth had seemed quite dirty at times and wondered if staff brushed his teeth.

On 8/9/18, at 8:56 a.m. nursing assistants (NA)-D and NA-H were observed providing morning cares for R48. NA's transferred R48 from the recliner where he slept in the dining area, into his wheelchair (w/c) via a standing lift. NA-H then propelled R48 into the tub room. NA-H and NA-D then transferred R48 via the standing lift onto the toilet. NA-D donned gloves and assisted the resident with washing his face then cleaned his hands and fingernails thoroughly. NA-D then obtained a clean washcloth and towel and washed and dried R48's underarms. R48 was swishing his mouth as if he had food or liquid in it. NA-D asked R48 if he needed to spit and brought a towel up to his mouth but the resident wouldn't spit. NA-D doffed her gloves and obtained toothettes to utilize for oral care but did not provide it. NA-D and NA-H then raised resident up and provided pericare; during that time licensed practical nurse (LPN)-A entered the tub room and completed a treatment to R48's bottom after pericare was completed. Once LPN-A completed the treatment, NA's then finished with

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dressing R48 and transferred him into his w/c. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care.

When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes.

Further review of R48's care plan, last revised 7/24/18, indicated the resident required extensive assist of one staff with eating, and to provide the resident with a calm, quiet setting at meal times with adequate eating time. The care plan further indicated R48 holds liquids/food in mouth and needs reminders to swallow.

On 8/6/18, at 5:50 p.m. R48 was continuously observed seated in his wheelchair (w/c) at the dining room table in Heritage Court during the supper meal; R48's meal was served at that time. At 6:00 p.m. nursing assistant (NA)-G addressed R48 and asked him if he was going to eat, NA-G was assisting another resident at the same table at that time. NA-G showed R48 that his spoon was on his plate; the resident had his hands wrapped up in his clothing protector at that time. At 6:05 p.m., licensed practical nurse (LPN)-C approached R48 to administer medications that were mixed in pudding. With assistance from NA-G, LPN-C eventually was able to administer the medications in pudding to the resident as he required verbal prompts and encouragement to swallow the medication as would swish it around in his mouth. The resident was observed to take a drink of his fluids independently but other than the pudding that the medications were mixed in,

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2 920	Continued From page 92 R48 still had not eaten any of his meal nor offered assistance. The resident continued to drink his fluids independently but would not attempt to eat his food. At 6:28 p.m., NA-K sat next to R48 and assisted the resident with eating his fruit, the resident had already consumed all of his fluids at that time. R48 accepted the offered food and ate approximately 50% of his fruit. At 6:40 p.m., NA-K got up from the table and heated up R48's meal in the microwave then set it on the table in front of R48. NA-K did not offer to assist R48 with eating his meal nor offer more fluids to the resident. At 6:55 p.m., R48 picked up his fork with a bite of potatoes on it, raised it slightly, then set it back down on the plate; R48 was not observed to eat any of his food other than the fruit he had been assisted with. When interviewed on 8/6/18, at 6:55 p.m. LPN-C stated R48 usually ate good on his own but was not having any of it tonight. LPN-C stated they would check with the resident later to see if he would eat a snack. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review pertinent policies and procedures related to grooming, audit resident care to ensure grooming needs are met and educate staff on the importance of grooming needs. The results of the audit could be reported during the quarterly quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21025	MN Rule 4658.0615 Food Temperatures	21025		9/19/18

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21025	Continued From page 93 Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure meal items were heated and served hot enough to reduce or prevent potential foodborne illness. Further, the facility failed to ensure 1 of 1 production mixers was kept in a clean and sanitary manner; and failed to ensure appropriate storage measures were implemented to prevent potential cross contamination of dried goods stored in non-original containers. These findings had potential to affect all 78 residents residing in the facility at the time of survey. Findings include: On 8/7/18, at 11:20 a.m. the lunch meal service was observed. Cook (CK)-A had several items on the steam table to be served to the resident population including taco meat, pork chops, mashed potatoes, sage dressing, kernel corn, tan gravy. In addition, CK-A had pureed carrots, pureed pork chops and mechanical soft texture pork chops and taco meat to be served. CK-A stated these items had just been removed from the oven and placed in the steam table a few moments prior. CK-A had documented temperatures on a flow sheet which identified just the taco meat and pork chops at appropriate temperatures for service. None of the other	21025	Corrected	

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21025	Continued From page 94 prepared items had temperatures recorded to demonstrate they had been checked for proper serving temperature to reduce the risk of foodborne illness. CK-A verified only the two meat options had been checked and stated he was going to check the other food items temperature upon return from being away from the kitchen. The surveyor requested a temperature check on the prepared items, and CK-A removed a bayonet-style thermometer from a coffee cup sitting on the counter which contained another thermometer, a scissors along with various pens and pencils. CK-A did not attempt to sanitize the thermometer before placing it in the prepared food items to be served. CK-A and the surveyor observed the thermometer, and CK-A stated aloud the following temperatures being identified for the various food items: Taco meat - 91 degrees Fahrenheit (F), Pork chop - 94 F, and, Sage dressing - 91 F. CK-A then turned to the surveyor and stated aloud, "What do you want me to do?" The surveyor asked CK-A what his normal process would be to implement if food temperatures were low, however, CK-A responded the residents' would be upset if the meal was too late and he did not want to overcook the food items. He stated he would wait five or 10 minutes with the food in the steam table and then recheck the temperature. Approximately 10 minutes later, CK-A checked the sage dressing and there was no temperature change, so he placed it back in the oven. CK-A did not check or place any of the other food items back into the oven to ensure they were hot enough to serve. At 11:45 a.m. CK-A checked all the food items and identified the	21025		

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following temperatures while they were in the steam table:

Taco meat - 91 F,
Pork chop - 94 F,
Sage dressing - 91 F,
Corn - 97 F,
Gravy - 81 F and,
In addition, all of the pureed and mechanical soft items were <100 F.

After obtaining the temperatures, CK-A unplugged the steam table and brought it to the main dining room despite the low temperatures being identified. CK-A then began to plate and serve the food from the steam table.

Dietary manager (DM)-A was alerted to these findings, and stated the food should have been re-heated to ensure a safe serving temperature. DM-A acknowledged the residents' would likely become upset with having to wait though, and added, "I know its bad, but what else can I choose to do? The residents will be upset." Further, DM-A stated the thermometer should not be stored in a cup with pencils and scissors, and should have been sanitized before used to check food temperatures.

On 8/9/18, at 10:30 a.m. a telephone interview was conducted with registered dietician (RD)-A. RD-A expressed food should only be served when hot enough, and she expected facility staff to understand and know the right food temperatures to serve at. Further, RD-A expressed if staff had any question of thermometer function, they should use another thermometer to check it before serving the food.

The facility's Food Thermometer policy dated

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7/2018, identified thermometers should be sanitized when removed from the casing, and before being inserted into food and/or fluids. The policy further indicated a water-and-detergent solution should be used to sanitize and remove food debris.

The facility's Food Temperature Monitoring policy dated 7/2018, identified a "Proper holding temperature" was required for food safety and listed, "cold food <41 degrees Fahrenheit, hot food >135 degrees Fahrenheit." The policy directed food should be cooked, reheated or cooled to ensure proper holding temperatures before each meal service, and listed a procedure which included the following steps:

- Before meal service, the cook/designee takes the "cook-to" and "serve" temperatures of "...all Time/temperature Control for Safety [TCS] menu items and records on the Food Temperature Record,"

- If temperatures are not within recommended guidelines, food and/or fluids are reheated to acceptable temperatures before service, and,

- TCS hot foods should be served at 135 degrees F or higher.

EQUIPMENT / STORAGE:

On 8/6/18, at 2:15 p.m. an initial kitchen tour was completed with dietary manager (DM)-A. A single, automatic can opener was on the counter which had visible red colored debris and dried substance running down the rear, forward facing backing of the device. A large floor based mixer and bowl was covered with a clear bag. The bag

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was removed and the mixer inspected which found areas of white colored, dried particles and smeared substance being stuck to the base of the extended arm portion where the mixing shaft is located (directly above the mixing bowl). A single plastic container of powdered sugar was on the counter which was approximately 1/4 full. Inside the container, a stainless steel, round non-handled scoop was sitting on top of the powdered sugar.

When interviewed at the same time, DM-A acknowledged the observations of the soiled equipment and stated the scoop should not be stored in the container.

A provided, undated Day and Evening Cook's listing identified several cleaning tasks to be completed. A bulletpoint directed staff to complete "... any other cleaning that needs to be done," and "kitchen should be spotless when you leave!" In addition, provided weekly cleaning sheets were reviewed and lacked any directed tasks to ensure floors, windows, screens nor fans were included.

A policy on food equipment cleaning was requested, but not provided.

SUGGESTED METHOD OF CORRECTION: The dietary manager could inservice staff on the importance of proper serving temperature of food. An audit could be implemented to ensure the temperature of the food is within the appropriate range. The results of the audit could be presented to the quality assurance committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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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 provide a clean, sanitary environment which was free of dust and debris in 1 of 1 main production kitchens used to prepare and serve food. In addition, the facility failed to ensure fluid and/or ice dispensing machines were kept in a clean, sanitary manner in 1 of 3 kitchenettes used. These findings had potential to effect affect all 78 residents currently residing in the facility. Findings include: KITCHEN: On 8/6/18, at 2:15 p.m. the initial kitchen tour was completed. A crank-style window was observed along the south side of the kitchen next to the dietary manager's office with a visible metallic screen covering the entire, inner aspect of the window. The screen had numerous visible areas of thick clumping dust, with cobwebs and several splatters of white and black colored bird droppings. In addition, a single oscillating fan was attached to the wall in the soiled dishes area. The fan blades' each had visible, clumping black colored dust attached to the surfaces of the	21685	Corrected	9/19/18

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blades. The fan was not turned on at this time.

During subsequent observation on 8/7/18, at 11:20 a.m. the window screen and fan continued to have the same appearance with visible clumping dust. There was no visible evidence the screen, nor the fan had been cleaned since first observed on 8/6/18.

On 8/8/18, at 10:00 a.m. the dietary manager (DM)-C observed and verified the appearance of the window screen and fan in the main production kitchen. DM-C stated the fan was cleaned by maintenance when they were notified to do so, and there was no formal cleaning schedule assigned to it. DM-C expressed it had likely been several weeks since the fan was last cleaned. Further, DM-C stated maintenance would also be responsible to clean the window screen.

A provided, undated Day and Evening Cook's listing identified several cleaning tasks to be completed. A bulletpoint directed staff to complete "... any other cleaning that needs to be done," and "kitchen should be spotless when you leave!" In addition, provided weekly cleaning sheets were reviewed and lacked any directed tasks to ensure floors, windows, screens nor fans were included.

No policies on kitchen cleanliness or maintenance were provided.

KITCHENETTE:
On 8/6/18, at 6:00 p.m. the central kitchenette was observed. A single juice machine was on the counter which had one spigot of juice able to be dispensed. The surface area of the machine behind the spigot was visibly soiled with dried, sticky substances running from the spigot area

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down to the drip tray. In addition, a single automatic ice dispenser was placed on the counter. The machine had visible white colored, flaky, dried sediment extending down the front surface of the device, and extended down and inside the attached drip tray. Further, a dual spigot automatic coffee maker had visible, chalky white colored sediment and debris extending along the seam for several inches where the drip tray attached to the machine.

On 8/7/18, at 8:00 a.m. the kitchenette was observed again. The same observed devices continued to be soiled as previously viewed on 8/6/18, with no evident cleaning being completed.

On 8/8/18, at 10:00 the kitchenette was toured with dietary manager (DM)-A. DM-A acknowledged the findings and stated the area should be cleaned by the evening cooks, and she would let them know.

DM-A provided a week listing of cleaning duties. The undated Thursday Cleaning Duties listing directed staff to, "Clean up juice machine." Further, Friday Cleaning Duties directed staff to, "Wipe down ice machine sides to."

A provided Day and Evening Cooks listing directed the evening cook staff to clean the coffee pots. It did not specify how often this was to be completed.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could work with the dietary manager to develop a cleaning schedule to ensure dust, debris, and kitchenettes are cleaned to maintain a safe, clean, environment. The administrator or designee could educate all

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21685	Continued From page 101 appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		