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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z0L1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245083**
2.STATE VENDOR OR MEDICAID NO.
(L2) **050095000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK HEALTH AND REHABILITATION CENTER**
(L4) **4415 WEST 36 1/2 STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55416**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **09/06/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **81** (L18)
13.Total Certified Beds **81** (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
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 09/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1979
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/13/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5083

On September 6, 2016, a Post Certification Revisit was completed to verify correction of deficiencies not corrected at the time of the July 21, 2015 revisit. We presumed, based on the facility's plan of correction, that the facility had corrected the deficiencies as of August 23, 2016. Based on our revisit, we have deteremined the facility has correctged the deficiencies issued pursuant to the July 21, 2016 revisit, as of August 23, 2016. As a result of this revisit, the Department discontinued the Category 1 remedy of State monitoring, as of August 23, 2016.

In addition, the Department recommended the following action related to the remedy outlined in our letter of August 2, 2016:

Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 1, 2016, be rescinded.

Since denial of payment did not go into effect. The facility would not be subject to a two year loss of NATCEP which was to begin, September 1, 2016.

Refer to the CMS 2567b , State form Revisit Report for health and CMS 2567b for life safety code.

Effective August 23, 2016, the facility is certified for 81 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245083

October 25, 2016

Ms. Yvonne Ferguson, Administrator
Park Health And Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

Dear Ms. Ferguson:

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 August 23, 2016 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 27, 2016

Mr. Charles O'Brien, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Project Number S5083026, H5083059, H5083060, H5083062

Dear Mr. O'Brien:

On August 2, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 7, 2016. (42 CFR 488.422)

On August 10, 2016, the Department as authorized by the Centers for Medicare and Medicaid Services (CMS), informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 1, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of August 10, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 1, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on June 1, 2016, that included an investigation of complaint numbers H5083059, H5083060, H5083062, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 21, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On September 6, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 23, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 21, 2016, as of August 23, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 23, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in our letter of August 2, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 1, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 1, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 1, 2016, is to be rescinded.

In our letter of August 2, 2016, 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 September 1, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 23, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245083 Y1	A. Building B. Wing Y2	9/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0242	Correction	ID Prefix F0329	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.25(l)	Completed
LSC	08/23/2016	LSC	08/23/2016	LSC	08/23/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	08/23/2016	LSC	08/23/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	09/28/2016	28230	09/06/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/1/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z0L1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245083**
2.STATE VENDOR OR MEDICAID NO.
(L2) **050095000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK HEALTH AND REHABILITATION CENTER**
(L4) **4415 WEST 36 1/2 STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55416**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **07/21/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **81** (L18)
13.Total Certified Beds **81** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NEII 08/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1979
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/13/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5083

On July 21, 2016 the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 15, 2016 the Minnesota Department of Public Safety completed a PCR to verify correction of deficiencies issued pursuant to the standard survey completed on June 1, 2016. In addition, the following substantiated complaints were found to be compliant:

H5083059 was investigated and substantiated at F309
H5083060 was investigated and substantiated at F250
H5083062 was investigated and substantiated at F309, F314.

Based on our visits we have determined the facility had not achieved substantial compliance with the deficiencies issued pursuant to the June 1, 2016 standard survey. The deficiencies not corrected are as follows:

F0176 - S/S: D - 483.10(n) - Resident Self-Administer Drugs If Deemed Safe
F0242 - S/S: D - 483.15(b) - Self-Determination - Right To Make Choices
F0329 - S/S: D - 483.25(l) - Drug Regimen Is Free From Unnecessary Drugs
F0431 - S/S: D - 483.60(b), (d), (e) - Drug Records, Label/store Drugs & Biologicals
F0441 - S/S: D - 483.65 - Infection Control, Prevent Spread, Linens

As a result of the revisit findings, this Department imposed the Category 1 remedy of State monitoring, effective August 7, 2016. In addition, the Department recommended the following enforcement remedy to the CMS Region V office for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 1, 2016. (42 CFR 488.417 (b))

If Denial of Payment goes into effect, the facility would be subject to a two year loss of NATCFEP, beginning September 1, 2016.

Refer to the CMS 2567b forms for both health and life safety code and CMS 2567 for health along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 2, 2016

Mr. Pat O'Brien, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Project Number S5083026, H5083059, H5083060 and H5083062

Dear Mr. O'Brien :

On June 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 1, 2016 that included an investigation of complaint number H5083059, H5083060, H5083062. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On July 21, 2016, the Minnesota Department of Health and on July 15, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on June 1, 2016. The deficiencies not corrected are as follows:

F0176 - S/S: D - 483.10(n) - Resident Self-Administer Drugs If Deemed Safe
F0242 - S/S: D - 483.15(b) - Self-Determination - Right To Make Choices
F0329 - S/S: D - 483.25(l) - Drug Regimen Is Free From Unnecessary Drugs
F0431 - S/S: D - 483.60(b), (d), (e) - Drug Records, Label/store Drugs & Biologicals
F0441 - S/S: D - 483.65 - Infection Control, Prevent Spread, Linens

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective August 7, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 1, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 1, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 1, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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, Park Health and Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 1, 2016. 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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 allegation of compliance and/or 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 December 1, 2016 (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.

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	R 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department 7/19/16 through 7/21/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on June 1, 2016. During this visit the following regulations were determined to be not corrected which are dilineated on the electronically delivered CMS 2567. In addition, complaint investigation numbers H5083059 (deficiency cited at F309), H5083060 (deficiency cited at F250) and H5083062 (deficiencies sited at F309 and F314) substantiated during the June 1, 2016 recertification survey were found corrected during the July 21, 2016 revisit. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 176} SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	{F 176}		8/23/16

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

Electronically Signed | 08/02/2016

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

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{F 176}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-medication assessment was followed for insulin injection for 1 of 3 residents (R90) reviewed for self-administration of medications. Findings include: On 7/20/16, at 11:05 a.m. a registered nurse (RN)-A reported a self-administration of medications (SAM) had been completed for R90 on 6/29/16. According to the assessment, it was determined a nurse was to be present in R90's room when he gave himself his insulin injections. R90's Novolog insulin vial was observed on 7/20/16, at 11:13 a.m. on the resident's bedside table. The vial was opened and approximately 2/3 full, and lacked a pharmacy label. R90's first name and a date of 6/28/16, was handwritten in black ink. R90 explained the label became wet and fell off the vial. Three insulin syringes in wrappers were also on the bedside table. Two of the wrappers were opened and syringes had been used and recapped. R90 said the syringes were for administering insulin, and he had opened and used one that morning at 8:00 a.m. One syringe was unopened, which R90 explained he planned to use at noon. Blood glucose testing results (numbers) were written on the wrappers. R90 stated he used the numbers so he could compare the number to his sliding scale chart which he had on the wall which indicated how much insulin he was supposed to self-administer. R90 stated he added 10 units to the number on the chart and then self-administered that amount of insulin. R90 said RN-B had not stayed in his	{F 176}	1. R90 was assessed for self administration of medications and care plan was updated. 2. Residents that reside at PHR have the potential to be at risk for this practice. Residents have been assessed and reviewed for self-administration as well as medication pass observations and will be ongoing quarterly, annually and with significant change. 3. Licensed nurses have been re-educated related to the facilities policies and procedures on self administration and medication administration. 4.DON/Designee audits 5 charts and observes medication administration for 4 weeks, then 2 charts and medication administration weekly x 3 months. 5. DON/Designee will forward results of self administration assessments and medication administration to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: 8/23/16	

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{F 176}	Continued From page 2	{F 176}		

room while he administered his insulin injection, and typically the nurses just tested his blood sugar, left pills in a cup, and left the room while he self-administered his medications. R90 said the prior evening the nurse "just gave" him his insulin because she was in a hurry and did not want to wait to observe R90. R90 stated he used to have a pill box that contained his medications, but the facility "took it away." R90 explained that the nurses now just left his pills for him to take later, and provided him with syringes.

R90's July 2016, physician orders indicated R90 received scheduled Novolog insulin three times daily before meals for diabetes and sliding scale Novolog insulin three times daily before meals as directed. Handwritten on the July 2016, physician orders for R90 indicated R90 may self-administer medication after set up by nurse.

R90's quarterly Minimum Data Set (MDS) dated 6/17/16, indicated the resident had intact cognition, displayed no behavioral concerns, and did not reject cares.

During an interview with RN-B on 7/20/16, at 11:35 a.m. RN-B stated he had seen R90's vial of opened, undated, and unlabeled Novolog insulin that morning when he took R90's blood glucose level. RN-B stated Novolog insulin was only good for 30 days after opening. RN-B explained he had handwritten the resident's first name and the date of 6/28/16, on the vial of insulin in R90's room. The reason he chose the date of 6/28/16, as that was the date the medication was delivered by the pharmacy. RN-B then left the vial of Novolog insulin and syringe in R90's room so he could self-administer the insulin. RN-B stated he never stayed in the room while R90 gave himself the

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{F 176}	Continued From page 3	{F 176}		

injection, and the nurse who trained him had done the same. RN-B stated in fact, R90 did not want him in the room when he gave himself the insulin injection. RN-B did not know whether R90's self-administration assessment showed the resident was capable, but he followed the medication administration record (MAR) instructions. RN-B stated he had not observed the two used insulin syringes on R90's bedside table that morning.

On 7/20/16, at 11:48 a.m. RN-E stated R90 kept his vial of insulin in a drawer in his room. At 11:58 a.m. RN-A verified the vial of Novolog insulin on R90's bedside table was opened, unlabeled, and approximately 2/3 full. In addition, she verified the presence of three syringes in wrappers. RN-A verified the self-administration assessment which noted staff needed to stay with the resident did not match the MAR which allowed the resident to self-inject the insulin. At 2:58 a.m. RN-A informed R90 he was not to have syringes in his room and removed them.

The following morning on 7/21/16, at 7:37 a.m. RN-B was observed performing blood sugar check on R90. RN-B asked R90 if he knew how much insulin to give and R90 said replied, "Yes--7 plus 10" units. R90 did not wash his hands, as he placed his unclean hand on the top of the opened vial and drew up the insulin. RN-B had turned away from the resident and had not seen the resident touch the opened vial with his hand where the insulin was drawn from. The surveyor informed RN-B of the observation. RN-B then told the resident to use a new syringe, and to wipe the top with an alcohol wipe. RN-B did not verify the amount of insulin, instruct the resident to remove excess air, or watch as the resident performed

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{F 176}	Continued From page 4	{F 176}		

the injection into his abdomen. RN-B stated R90 recapped his syringes after using them. Sometimes he did this well, and other times he required re-education. RN-B stated R90 was allowed to keep his insulin in his drawer and then he informed the RN "how it went."

On 7/21/16, at 2:50 p.m. the interim director of nursing (IDON) stated all insulins had recently been removed from R90's room and no insulin should have been stored there. She was unaware syringes had been left in R90's room and stated he must have acquired them on his own. If a resident was self-administering medications, it was supposed to have been noted on the MAR, and nurses were expected to follow the directive. The IDON said R90's self-administration was stopped two weeks prior, and the nurse practitioner was was informed yesterday, as there were concerns regarding the resident's non-compliance and risk for infection. The IDON said risk/benefit assessments should have been competed at least quarterly and care planned, and she planned to compete another assessment for R90.

Review of R90's Self-Medication Data Collection and Assessment dated 6/29/16, with RN-A's signature on the bottom of the assessment indicated "Resident [R90] may draw up insulin and administer in front of a nurse." Review of the July 2016 Diabetic Flow Record Self Administers (MAR) indicated "Resident [R90] may draw up his own insulin and inject with nurse-can keep insulin locked in his Drawer. Nurse will Administer a needle each time. 07/16"

The facility's 7/15, Self-Medication Assessment and Management policy indicated "The center

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{F 176}	Continued From page 5 uses the Self Medication Data Collection and Assessment form to evaluate resident's ability to self-medicate safely...Enter resident's specific interventions and goals on the Plan of Care."	{F 176}		
{F 242} SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor bathing choices for 1 of 3 residents (R4) interviewed for choices. Findings include: R4 stated on 7/19/16, at 11:16 a.m. the staff had recently asked him how frequently he preferred bathing. He informed the staff he would like a shower three times weekly, and bathing in some form every day. R4 said he was told by facility staff that bathing residents with that frequency would not allow the staff to get anything else completed. R4's quarterly Minimum Data Set (MDS) dated 6/9/16, indicated the resident was cognitively intact, displayed no behavioral symptoms and needed extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene	{F 242}	1. R4 was interviewed for bathing preference and care plan has been updated. 2. Residents that resident at PHR have the potential to be affected by this practice. Resident interviews have been completed and care plans have been updated in regards to resident bathing preferences. Residents are interviewed upon admission, quarterly and as needed regarding bathing preferences. Resident preferences are also reviewed at care conferences. Care plans have been updated to reflect resident choice for bathing. 3. Staff have been educated on providing choices to residents in regards to bathing and in accordance of their plan of care. 4. DON/Designee will conduct audits 3x per week, then monthly x 3 months on	8/23/16

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{F 242}	Continued From page 6 and physical help with bathing. R4's care plan indicated staff were to assist R4 per resident choice and offer bathing on Mondays, Wednesdays and Friday on the afternoon shift. The care plan had boxes to check, and shower, tub bath and/or bed bath preference was not checked. A nursing assistant (NA) group sheet bath schedule indicated R4 was to be given a bath on the afternoon shift on Thursdays. On 7/20/16, a registered nurse (RN)-A explained bathing choices were determined at care conferences and documented on care plans and NA assignment sheets. RN-A also said residents could choose bathing with the frequency they wished, and there was sufficient staff to accomplish this task. RN-D stated on 7/20/16, at 1:51 p.m. she had interviewed all residents on 7/20/16, and R4 requested three baths weekly. RN-D said she was reinforcing this choice, however, RN-D confirmed the NA group sheet bath schedule directed staff to bathe R4 once weekly. RN-D edited the schedule and resident's care plan at the time of the interview to reflect three times weekly bathing. On 7/20/16, at 3:21 p.m. the bath report was reviewed with the director of nursing services (DNS.) The bath report indicated R4 had one bath on 7/15/16, and all other baths were noted as "not scheduled." The DNS said R4 had refused bathing, which was then documented as "not scheduled." On 7/20/16, at 3:31 p.m. R4 stated he had not been offered some type of daily bathing since 7/11/16, although he had been given a bed bath	{F 242}	bathing preference being provided to the residents per individualized plan of care. 5. DON/Designee will forward results of all care audits to the QAPI committee monthly x 3 months for continues opportunities for quality improvements. 6. Completion date: 8/23/16	

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{F 242}	Continued From page 7 on 7/15/16. Following the interview with R4, NA-C explained the NAs documented "refused" when residents refused bathing and documented "not scheduled" when residents did not have a scheduled bath that day. On 7/21/16, at approximately 4:00 p.m. the interim director of nursing (IDON) stated it was difficult for staff to perform bathing three times weekly, but they should have been able to accommodate bathing twice weekly. A facility bath policy was requested, but was not received.	{F 242}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	{F 329}		8/23/16

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{F 329}	Continued From page 8 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication was administered only with adequate indications and with appropriate monitoring for 3 of 3 residents (R32, R20, R78) whose medications were reviewed. Findings include: R32's physician's orders dated 7/12/16, included gabapentin (anticonvulsant commonly used for nerve pain) of 600 milligrams (mg) once daily and to lorazepam (anti-anxiety) 0.5 mg twice daily as needed (PRN). R32's care plan dated 6/15/16, indicated a diagnosis of anxiety, neuropathic pain and dementia. R32 was legally blind and required assistance of one staff with walker for ambulation. Interventions included helping the resident steer his during ambulation and administer medications per physician orders. The medication administration record (MAR) for R32 was reviewed on 7/21/16, at 1:00 p.m. From 7/11 to 7/21/16, R32 received PRN lorazepam on 7/15/16, however, there were no indications why the medication was administered or the efficacy of the medication. In addition, gabapentin was not initialed as being given seven out of 11 days. On 7/15/16, the medication was initialed and circled. The back the MAR and/or progress, however,	{F 329}	1. R32 has been re-assessed for appropriate medication regimen and care plan has been updated to reflect adequate indications and appropriate monitoring. R20 and R78 have been comprehensively reassessed for pain and care plan was revised to ensure medication that is administered has adequate indications and appropriate monitoring. 2. Residents at PHR have the potential to be affected by this practice. Care plans for residents who experience pain have been reviewed and updated to reflect appropriate pain management as well as adequate indications and appropriate monitoring. The physician has been updated and care plans reflect changes as needed. 3. Licensed nurses have been educated on pain management, documentation of administering a pain medication, and resident refusals of medications/treatments. 4. DON/Designee will conduct audits of PRN medication and follow up on effectiveness, documentation of efficacy and physician orders 3x per week x 4 weeks, then 3x per month x 3 months. 5. DON/Designee will forward all pain medication audits to the QAPI committee	

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{F 329}	Continued From page 9 noted lacked an explanation as to why the medication was not given and why it was circled on 7/15/16. R20's physicians orders dated 7/14/16, included Q-Tussin DM (for cough) of 5 milliliters (ml) every four hours PRN, and oxycodone HCL (narcotic pain medication) of 5 mg every four hours PRN. R20's diagnoses included chronic low back pain and dementia and. The MAR from 7/11 to 7/21/16, revealed initials indicating medications had each been administered six times, however, no indications or efficacy was noted on the back of the MAR or in the progress notes. On 7/21/16, at 1:15 a.m. the interim director of nursing (IDON) and surveyor reviewed the R32's MAR. The IDON verified R32's medications had not been signed out by the nurse as given. In addition, neither R32 nor R20 had documentation as to why PRN medication had been administered or its effectiveness noted. The IDON's expectation was for staff to sign/initial that a medication had been given or was not given, and to document reasons PRNs were administered and their effectiveness. The note was to be signed and dated. The IDON verified that since the last survey, nurse managers on each floor were responsible for checking the MARs daily for any missed medications. The floor nurse was to double check the MARs at the end of their shift to ensure all medications had been given/signed out. The IDON stated, "Unfortunately this has not been happening. Some medication have been missed. We are in the process of working on this issue. " The facility's 7/15, Procedure for Medication Administration directed staff to document on the	{F 329}	monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: 8/23/16	

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{F 329}	Continued From page 10 MAR as soon as the medication was given, indicate refused or omitted medication by circling and initial on the MAR, and indicate reason in a nursing note or on the back of the MAR. R78 was interviewed on 7/19/16, at 3:23 p.m. regarding pain level and pain medication. R78 said the facility had changed his pain medication from Oxycontin (a time released pain form of the narcotic pain medication Oxycodone) to Oxycodone 10 milligrams (mg) every four hours. R4 said the pain pill gave him relief for about three hours. R4 said he had been up all night from pain, describing the pain as an 8/10 (with 10 being the worst pain.) R78's quarterly Minimum Data Set (MDS) dated 7/6/16, indicated the resident was generally cognitively intact. R78's Admission Record indicated diagnoses of paranoid schizophrenia, peripheral vascular disease, chronic ulcers of the left and right foot and chronic pain syndrome. R78's care plan for pain management indicated R78 had neuropathic pain, bilateral foot wounds and chronic pain. The care plan directed staff to administer pain medication before and after wound cares and to monitor and record the effectiveness of pain medications. The care plan further directed staff to assess for verbal and non-verbal signs and symptoms of pain unrelieved by ordered treatments and medications and to report these signs and symptoms to the medical provider. R78's pain assessment dated 7/1/16, directed staff to give Oxycodone 5 mg, 2 tablets before and after wound cares if four hours had passed from the last dose given. The pain assessment indicated	{F 329}		

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{F 329}	Continued From page 11 Oxycodone relieved R78's pain. The medication record (MAR), narcotic count book and nursing progress notes were reviewed from 7/11 to 7/19/16, with a registered nurse (RN-D) and the following was noted: 1) Physician's orders for R78 directed the resident could receive Oxycodone 5 mg two tablets every four hours as needed. 2) The MAR directed staff to ask the resident "Is your pain program effective for you? If no, provide pain rating." The MAR further directed staff to utilize the Wong-Baker pain scale (facial descriptors with 0-10 ratings, with 10 being the worst pain). 3) The narcotic count book, MAR and nursing progress notes were inconsistent regarding both Oxycodone doses given and pain medication relief. On 7/11/16, the narcotic count book indicated R78 was given Oxycodone twice. No Oxycodone doses were charted in the MAR, and no pain relief was documented on the MAR. On 7/14/16, the narcotic count book indicated R78 was given Oxycodone once. The MAR indicated R78 received Oxycodone twice, and pain relief was documented once on the MAR. On 7/16/16, no Oxycodone doses were documented in the narcotic count book, two Oxycodone doses were charted in the MAR, and pain relief was documented once on the MAR. On 7/18/16, the narcotic count book indicated R78 was given three Oxycodone doses, one Oxycodone dose was documented in the MAR, and pain relief was documented once in the MAR.	{F 329}		

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{F 329}	Continued From page 12 On 7/19/16, the narcotic count book indicated R78 received Oxycodone doses five times, five Oxycodone were documented in the MAR, and pain relief was documented three times. Pain relief documentation was lacking in the nursing progress notes dated 7/11 to 7/19/16. RN-D confirmed R78's pain medication and pain was documented inconsistently. On 7/21/16, the director of nursing services (DNS) reported the facility staffs' documentation of pain medications had "come a long way" and "luckily" staff had signed out most medications in the narcotic count book. The DNS further stated it was her expectation pain relief would be documented at least once per shift. On 7/21/16, the interim director of nursing stated it was her expectation pain relief would have been documented with each pain medication administration. The facility's 7/1/15, Pain Management Programs directed staff have assessed residents' pain medication effectiveness frequently.	{F 329}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	{F 431}		8/23/16

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{F 431}	Continued From page 13 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were properly labeled and stored for 3 of 3 residents (R5, R32, R90) when medication storage was reviewed. Findings include: R5's carbamazepine (anticonvulsant) medication was prepared for administration and stored in the locked medication cart on 7/20/16, at 10:35 a.m. during a review of the medication storage system.	{F 431}	1. R5 no longer resides at the facility. R32 and R90 medications have been properly labeled and stored. 2. Residents that reside at PHR have the potential to be affected by this practice. The policy and procedure for refusing medication and on storage and labeling of medication has been reviewed and is current. 3. Licensed nurses, as well as the DON have been educated on the policy and procedure on medication refusals and	

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{F 431}	Continued From page 14 A registered nurse (RN)-B explained R5 had refused "that medication every day" as she did not want to take it with her other medications. RN-B verified the medication was carbamazepine 200 milligrams (mg) 1 tablet twice daily. RN-B stated, "After I give it to her I call and let the doctor know" so the next medication administration could then be rescheduled. RN-A informed the surveyor they were planning on allowing R5 to self-administer the carbamazepine. RN-A said she would look into how many times the resident had refused to take the medication, and whether the physician had been updated. On 7/20/16, at 11:18 a.m. R5 stated she routinely did not take the carbamazepine with the other medications, as it made her dizzy and nauseated when taken together. On days she had dialysis (Monday, Wednesday, and Friday) she brought the medication with her to dialysis. On days she did not have dialysis, she took the medication just before lunch. The resident stated her preference would have been to take it once daily in the evening. At approximately 11:30 a.m. RN-A said she verified there was no evidence in R5's record her doctor had ever been notified the resident was not taking her medication at the prescribed time. R5's medication administration record (MAR) for 7/11 to 7/20/16, revealed the resident's carbemazepine was taken every day at 8:00 a.m. and 4:00 p.m. On 7/20/16, at 10:35 a.m. the MAR was signed off by RN-B that R5 had taken the medication when in fact it was still in the medication cart.	{F 431}	storage. 4. DON/Designee will conduct audits on the process of medication labeling and storage 3x per week x 4 weeks then 3 x per month x 3 months. 5. DON/Designee will forward all medication storage, medication labeling, and refusal audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: 8/23/16	

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{F 431}	Continued From page 15 The interim director of nursing verified the staff later re-offered medications when residents did not take their medications, and then notified the physician if they refused their medications. The surveyor requested documentation of physician notifications, but no documentation was provided. The IDON said this was not noted on the facility policy, nor did the policy indicate staff could leave prepared medications in the medication drawers. R32's medications were found in the narcotic box on 7/20/16, at 10:50 a.m. The medications were in a medication cup with what appeared to be applesauce. There was no label indicating who the medications belonged to or what medications were in the cup. When asked about the observation, RN-B stated the cup contained a supplement for "nutrition." When asked about the pills in the cup, RN-B stated the cup contained R32's pills in applesauce. When asked whether the cup contained all of the resident's morning medications RN-B said he was unsure, as he had given R32 a spoon full of the medications "here and there" so was unable to verify what medication remained. RN-B verified R32 had not taken all of her 8:00 a.m. medications in the applesauce, and at 12:00 p.m. the resident was scheduled to receive three of those same medications. Following the observation, RN-A explained that staff had been instructed to give R32 one medication at a time due swallowing problems. RN-A also verified medications readied for administration should not have been left in the drawer if they were not going to be administered. R32's a.m. physician orders included: Allopurinol	{F 431}		

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{F 431}	Continued From page 16	{F 431}		

100 mg (gout), aspirin 81 mg (preventive), certovite 18 mg-0.4 (vitamin), citalopram 40 mg (antidepressant), cranberry capsule 400 mg (urinary tract infection), digoxin 125 mg (cardiac), Cymbalta 20 mg (antidepressant), furosemide 20 mg (fluid retention) K-Lor-Con 10 milliequivalents (scheduled at 6:00 a.m.), metoprolol 50 mg (cardiac), Prilosec (ordered to be given at 7:30 a.m.) 20 mg, Risperidone 0.25 mg (antipsychotic), vitamin D soft gel 1000 units, as well as three medications scheduled at 8:00 a.m. and again at noon: Methazolamide 50 mg three times daily (glaucoma), Mytab gas 80 mg (antacid), Tylenol 1000 mg three times daily (pain).

R90's Novolog insulin vial was observed on 7/20/16, at 11:13 a.m. on the resident's bedside table. The vial was opened and approximately 2/3 full, and lacked a pharmacy label. R90's first name and a date of 6/28/16, was handwritten in black ink. R90 explained the label became wet and fell off the vial. Three insulin syringes in wrappers were also on the bedside table. Two of the wrappers were opened and syringes had been used and recapped. R90 said the syringes were for administering insulin, and he had opened and used one that morning at 8:00 a.m. One syringe was unopened, which R90 explained he planned to use at noon. R90 stated he used to have a pill box that contained his medications, but the facility "took it away." R90 explained that the nurses now just left his pills for him to take later, and provided him with syringes.

During an interview with RN-B on 7/20/16, at 11:35 a.m. RN-B stated he had seen R90's vial of opened, undated, and unlabeled Novolog insulin that morning when he took R90's blood glucose

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{F 431}	Continued From page 17 level. RN-B stated Novolog insulin was only good for 30 days after opening. RN-B explained he had handwritten the resident's first name and the date of 6/28/16, on the vial of insulin in R90's room. The reason he chose the date of 6/28/16, as that was the date the medication was delivered by the pharmacy. RN-B stated he had not observed the two used insulin syringes on R90's bedside table that morning. On 7/20/16, at 11:48 a.m. RN-E stated R90 kept his vial of insulin in a drawer in his room. At 11:58 a.m. RN-A verified the vial of Novolog insulin on R90's bedside table was opened, unlabeled, and approximately 2/3 full. On 7/21/16, at 2:50 p.m. the interim director of nursing (IDON) stated all insulin's had recently been removed from R90's room and no insulin should have been stored there. If a resident was self-administering medications, it was supposed to have been noted on the MAR, and nurses were expected to follow the directive. A medication policy was requested, but was not received.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	{F 441}		8/23/16

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{F 441}	Continued From page 18 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow infection control standards for minimizing infection for 1 of 1 resident (R42) whose wound dressing change was observed, and to properly discard of used insulin syringes for 1 of 1 resident (R90) who had used syringes in his room. Findings include:	{F 441}	1. R42 dressing change orders were reviewed. Nurse completing the dressing change was educated. R90 self administration evaluation reviewed. Insulin and syringe were removed from resident room. 2. Residents that reside at PHR who receive wound treatments and self administer insulin have the potential to be	

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{F 441}	Continued From page 19 R42's clean wound dressing change was observed on 7/21/16 at 9:42 a.m. performed by a registered nurse (RN)-C. RN-C gathered supplies required for the dressing change and donned gloves. She then removed a scissor from her pocket and cut off the old dressing off R42's right foot. She then removed and discarded the old dressing, and returned the scissor to her pocket. RN-C discarded her gloves and wet a wash cloth, which she used to cleanse the resident's foot, and then dried it with a towel. RN-C washed her hands, donned new gloves and opened the new dressing package. RN-C again took the scissor from her pocket to shape the sterile dressing to fit the wound, and then placed the scissor on the resident's bed. The scissor was not cleaned in any way between the removal of the old dressing and preparation of the new, sterile dressing to minimize the risk for contamination of clean supplies and potential infection. RN-C was interviewed regarding the observation on 7/21/16 at 10:09 a.m. She stated, "I always clean them with alcohol between patients, but I get what you're saying. I shouldn't use them on the dressing after using them to remove the old dressing." A face sheet identified R42 was admitted to the facility with diabetic foot ulcers on both feet and peripheral vascular disease, both associated with an increased risk of wound infection. R42's careplan dated 12/28/15, identified R42 to be at risk for infection and indicated skin impairment of the bottom of the right foot. The careplan directed staff to monitor the wound weekly, provide treatment per physician orders and update the physician if no evidence of healing.	{F 441}	affected. Residents whom receive wound treatments have wound care stations set in room to ensure proper equipment and standards of practice are in place. Residents whom self administer insulin have had their rooms checked for properly labeled medication and to ensure no syringes were in room. 3. Licensed nurses and TMA's educated on sound treatment procedure. 4. DON/Designee conduct audits on dressing change procedures and self administration of insulin 3x per week x 4 weeks and 3x per month thereafter. 5. DON/Designee will forward all audits to QAPI committee monthly for 3 months for continued opportunities for quality improvement. 6. Completion date: 8/23/16	

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{F 441}	Continued From page 20 R42's physician orders signed 7/1/16, directed staff to apply dry Iodoflex to all wound beds, cover with gauze/gauze pads, wrap with Conform, apply Bivalve cast at all times when foot is in contact with the ground. A 7/15/16, skin assessment identified R42 had a diabetic foot ulcer on her right foot that measured 2.6 centimeters (cm) in length x 2.8 cm in width and had 0.1 cm of depth. RN-D was interviewed on 7/21/16, at 10:20 a.m. and said she would have expected nurses keep the dirty removal of an old dressing and clean preparation and application of a new dressing separate. This would include the use of clean scissors with the preparation of a new, clean dressing. The director of nursing asked at 1:15 p.m. "Scissors are not covered in our policy, are they?" R90's Novolog insulin vial was observed on 7/20/16, at 11:13 a.m. on the resident's bedside table. Three insulin syringes in wrappers were also on the bedside table. Two of the wrappers were opened and syringes had been used and recapped. R90 said the syringes were provided by the nurses, and he used them to administer insulin. He had opened and used one that morning at 8:00 a.m. One syringe was unopened, which R90 explained he planned to use at noon. During an interview with RN-B on 7/20/16, at 11:35 a.m. RN-B that although he had been in R90's room and left insulin, he had not noticed the two used insulin syringes on R90's bedside table that morning.	{F 441}		

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{F 441}	Continued From page 21 On 7/20/16, at 11:58 a.m. RN-A verified the presence of three syringes in R90's room. At 2:58 a.m. RN-A informed R90 he was not to have syringes in his room and removed them. The following morning on 7/21/16, at 7:37 a.m. RN-B performed a blood sugar check on R90. Without first washing his hands, R90 placed his unclean hand on the top of the opened vial and drew up the insulin. RN-B had turned away from the resident and had not seen the resident touch the opened vial with his hand where the insulin was drawn from. The surveyor informed RN-B of the observation. RN-B then told the resident to use a new syringe, and to wipe the top with an alcohol wipe. RN-B stated R90 recapped his syringes after using them. Sometimes he did this well, and other times he required re-education. On 7/20/16, at 11:05 a.m. a registered nurse (RN)-A reported a self-administration of medications (SAM) had been completed for R90 on 6/29/16. According to the assessment, it was determined a nurse was to be present in R90's room when he gave himself his insulin injections. R90's Novolog insulin vial was observed on 7/20/16, at 11:13 a.m. on the resident's bedside table. The vial was opened and approximately 2/3 full, and lacked a pharmacy label. R90's first name and a date of 6/28/16, was handwritten in black ink. R90 explained the label became wet and fell off the vial. Three insulin syringes in wrappers were also on the bedside table. Two of the wrappers were opened and syringes had been used and recapped. R90 said the syringes were for administering insulin, and he had opened and used one that morning at 8:00 a.m. One syringe was unopened, which R90 explained he planned to use at noon. Blood glucose testing	{F 441}		

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{F 441}	Continued From page 22	{F 441}		

results (numbers) were written on the wrappers. R90 stated he used the numbers so he could compare the number to his sliding scale chart which he had on the wall which indicated how much insulin he was supposed to self-administer. R90 stated he added 10 units to the number on the chart and then self-administered that amount of insulin. R90 said RN-B had not stayed in his room while he administered his insulin injection, and typically the nurses just tested his blood sugar, left pills in a cup, and left the room while he self-administered his medications. R90 said the prior evening the nurse "just gave" him his insulin because she was in a hurry and did not want to wait to observe R90. R90 stated he used to have a pill box that contained his medications, but the facility "took it away." R90 explained that the nurses now just left his pills for him to take later, and provided him with syringes.

R90's July 2016, physician orders indicated R90 received scheduled Novolog insulin three times daily before meals for diabetes and sliding scale Novolog insulin three times daily before meals as directed. Handwritten on the July 2016, physician orders for R90 indicated R90 may self-administer medication after set up by nurse.

R90's quarterly Minimum Data Set (MDS) dated 6/17/16, indicated the resident had intact cognition, displayed no behavioral concerns, and did not reject cares.

During an interview with RN-B on 7/20/16, at 11:35 a.m. RN-B stated he had seen R90's vial of opened, undated, and unlabeled Novolog insulin that morning when he took R90's blood glucose level. RN-B stated Novolog insulin was only good for 30 days after opening. RN-B explained he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	R 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

(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 441}	Continued From page 23	{F 441}		

handwritten the resident's first name and the date of 6/28/16, on the vial of insulin in R90's room. The reason he chose the date of 6/28/16, as that was the date the medication was delivered by the pharmacy. RN-B then left the vial of Novolog insulin and syringe in R90's room so he could self-administer the insulin. RN-B stated he never stayed in the room while R90 gave himself the injection, and the nurse who trained him had done the same. RN-B stated in fact, R90 did not want him in the room when he gave himself the insulin injection. RN-B did not know whether R90's self-administration assessment showed the resident was capable, but he followed the medication administration record (MAR) instructions. RN-B stated he had not observed the two used insulin syringes on R90's bedside table that morning.

On 7/20/16, at 11:48 a.m. RN-E stated R90 kept his vial of insulin in a drawer in his room. At 11:58 a.m. RN-A verified the vial of Novolog insulin on R90's bedside table was opened, unlabeled, and approximately 2/3 full. In addition, she verified the presence of three syringes in wrappers. RN-A verified the self-administration assessment which noted staff needed to stay with the resident did not match the MAR which allowed the resident to self-inject the insulin. At 2:58 a.m. RN-A informed R90 he was not to have syringes in his room and removed them.

The following morning on 7/21/16, at 7:37 a.m. RN-B was observed performing blood sugar check on R90. RN-B asked R90 if he knew how much insulin to give and R90 said replied, "Yes--7 plus 10" units. R90 did not wash his hands, as he placed his unclean hand on the top of the opened vial and drew up the insulin. RN-B had turned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	R 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

(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 441}	Continued From page 24	{F 441}		

away from the resident and had not seen the resident touch the opened vial with his hand where the insulin was drawn from. The surveyor informed RN-B of the observation. RN-B then told the resident to use a new syringe, and to wipe the top with an alcohol wipe. RN-B did not verify the amount of insulin, instruct the resident to remove excess air, or watch as the resident performed the injection into his abdomen. RN-B stated R90 recapped his syringes after using them. Sometimes he did this well, and other times he required re-education. RN-B stated R90 was allowed to keep his insulin in his drawer and then he informed the RN "how it went."

On 7/21/16, at 2:50 p.m. the interim director of nursing (IDON) stated all insulin's had recently been removed from R90's room and no insulin should have been stored there. She was unaware syringes had been left in R90's room and stated he must have acquired them on his own. If a resident was self-administering medications, it was supposed to have been noted on the MAR, and nurses were expected to follow the directive. The IDON said R90's self-administration was stopped two weeks prior, and the nurse practitioner was was informed yesterday, as there were concerns regarding the resident's non-compliance and risk for infection. The IDON said risk/benefit assessments should have been competed at least quarterly and care planned, and she planned to compete another assessment for R90.

Review of R90's Self-Medication Data Collection and Assessment dated 6/29/16, with RN-A's signature on the bottom of the assessment indicated the resident could administer his own insulin, however, an addition dated 7/16 read,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	R 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

(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 441}	Continued From page 25 "Nurse will Administer a needle each time." On 7/21/16, at 2:50 p.m. the interim director of nursing (IDON) stated she was unaware syringes had been left in R90's room and stated he must have acquired them on his own. When the surveyor asked to speak to the infection control nurse, the IDON stated the infection control nurse had left employment with the facility a week and a half earlier, and the plan was to incorporate the role into one of the two nurse manager positions. Review of R90's Self-Medication Data Collection and Assessment dated 6/29/16, with RN-A's signature on the bottom of the assessment indicated "Resident [R90] may draw up insulin and administer in front of a nurse." Review of the July 2016 Diabetic Flow Record Self Administers (MAR) indicated "Resident [R90] may draw up his own insulin and inject with nurse-can keep insulin locked in his Drawer. Nurse will Administer a needle each time. 07/16" Infection control policies were requested, however, were not provided.	{F 441}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245083 Y1	A. Building B. Wing Y2	7/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016
ID Prefix F0241	Correction	ID Prefix F0250	Correction	ID Prefix F0279	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(g)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016
ID Prefix F0280	Correction	ID Prefix F0281	Correction	ID Prefix F0282	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016
ID Prefix F0309	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016
ID Prefix F0323	Correction	ID Prefix F0333	Correction	ID Prefix F0425	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(m)(2)	Completed	Reg. # 483.60(a),(b)	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GL/mm	08/02/2016	32976	07/21/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245083 Y1	A. Building B. Wing Y2	7/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0463	Correction	ID Prefix F0520	Correction		
Reg. # 483.70(f)	Completed	Reg. # 483.75(o)(1)	Completed		
LSC	07/11/2016	LSC	07/11/2016		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GL/mm	08/02/2016	32976	07/21/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/1/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245083	A. Building 01 - MAIN BUILDING 01 B. Wing	7/15/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 07/11/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/24/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 08/02/2016	SIGNATURE OF SURVEYOR 37009	DATE 07/15/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/24/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z0L1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245083**
2.STATE VENDOR OR MEDICAID NO.
(L2) **050095000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK HEALTH AND REHABILITATION CENTER**
(L4) **4415 WEST 36 1/2 STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55416**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**
6. DATE OF SURVEY **06/01/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **81** (L18)
13.Total Certified Beds **81** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NEII 07/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1979
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5083

A standard survey was completed at this facility and found the facility was not in substantial compliance with Federal participation requirements. In addition, the following complaint investigations were conducted and found substantiated:

H5083059 was investigated and substantiated at F309
H5083060 was investigated and substantiated at F250
H5083062 was investigated and substantiated at F309, F314

The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code, along with the facilitys plan of correction.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 21, 2016

Ms. Cynthia Anderson, Administrator
Park Health & Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Projects Numbered S5083026, H5083059, H5083060, and H5083062

Dear Ms. Anderson:

On June 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 1, 2016 standard survey the Minnesota Department of Health completed an investigation of complaints numbered H5083059 which was substantiated at F309, H5083060 which was substantiated at F250, H5083062 which was substantiated at F309 & F314.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 11, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 11, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	06/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility'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. H5083059 was investigated and substantiated at F309 H5083060 was investigated and substantiated at F250 H5083062 was investigated and substantiated at F309, F314	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		7/11/16

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

Electronically Signed | 07/01/2016

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

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician with significant changes in condition for 1 of 2 residents (R31) who experienced significant medical changes. Findings include: R31 had a significant event with severe edema (excess fluid in the tissue) of her legs leading to fluid weeping from her legs. Medication orders that may have contributed to the edema were not correctly documented for proper physician notification. On 5/24/16, at 10:29 a.m. a family member (F)-C was interviewed and explained the course of events leading up to R31's edema. F-C explained at the time of admission on 4/21/16, R31 was walking, eating and was mentally alert. F-C	F 157	1. R31 no longer resides in the center. 2. Residents that reside at PHRC have the potential to be affected by this practice. Residents identified with a change in condition in the past 30 days have been assessed and plans of care have been reviewed and updated. Physicians will be notified as needed and plans of care will be updated to reflect any changes. 3. Licensed Nurses have been re-educated related to the facilities policies and procedures on change of condition. Communication from shift to shift on resident status and change will occur over the 24 hour report. The facilities acute change in resident status reports will be pulled by DON/Designee M-F and residents triggering for a change	

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F 157	Continued From page 2 believed staff were supposed to have been elevating the resident's legs at all times due to the edema. However, when F-C visited daily she found R31's legs were not elevated. F-C stated it was "a struggle" to get a recliner that worked properly to keep R31's legs up. When F-A arrived for her daily visit on 5/20/16, R31 was sitting in the recliner with legs down. R31's legs were very swollen, her pant legs and socks were wet and there was a puddle of fluid on the floor by her feet, and the resident was confused. F-C quickly notified the staff of the situation, was upset, and requested to file a formal complaint. On 5/25/16, at 7:18 a.m. a nursing assistant (NA)-C was observed assisting R31. NA-C asked R31 if she would like to put her feet up. R31 initially declined, but, then agreed to put feet up with encouragement. The Comprehensive Admission Data collection and Assessment, dated 4/21/16, indicated no edema was present. A nursing noted, dated 4/24/16, indicated R31 had 2+ pitting edema (a situation in which the swelling is severe enough to leave a dent in the skin for 10 to 15 seconds when pressed with the finger). On 4/25/16, a nursing note again identified 2+ pitting edema. The 4/16 medical administration record (MAR) indicated 2+ edema from 4/24/16 through 4/30/16. An admission physician (MD) progress note dated 4/27/16, noted no edema. The progress note included diagnoses that could have contributed to edema including chronic kidney disease stage 3 and congestive heart failure. The	F 157	will have an assessment completed, Care plan update, MD and family notification as needed. Residents identified with a change in condition will be reviewed through the facilities clinical meeting process for follow-up. 4. DON/Designee will review residents with a change in their health status and complete audits to assure notification of emergency contacts and MD occur with changes in condition. Audits will be completed M-F x 4 weeks, then 3x weekly x 3 months. 5. DON/Designee will forward all reviews of change in condition program audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11, 2016	

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F 157	Continued From page 3 plan was to continue to monitor. On 5/2/16, nursing notes again reflected bilateral edema of all four extremities as well as wheezing. The degree of edema was not indicated. The MD was notified, and telephone orders dated 5/2/16, indicated a diagnosis of wheezing with orders for in house psychology, and a medication to help with breathing. The edema was not addressed. On 5/3/16, a telephone order was written for 1 gram of sodium and restricted fluids both for seven days due to R31's low sodium. On 5/12/16, a nurse practitioner (NP)-A's note indicated 1+ edema. On 5/13/16, a nursing note indicated 1+ edema of the lower extremities and R31 was encouraged to keep feet elevated. On 5/16/16 a nursing note indicated R31 had a weight gain over two pounds in two days with "ongoing 2+ pitting edema" and NP-A was notified. The MAR for 5/16, included an order for sodium 1 gram daily for 14 days dated 5/10/16. It was unclear whether the MD was aware of the order, as there was no corresponding signed telephone order. A telephone order, dated 5/16/16, indicated a diagnosis of anxiety with anxiety medication ordered. On 5/19/16, a nursing note indicated 2+ bilateral edema and the resident was being encouraged to elevate her legs. On 5/20/16, "writer called physician" but the note did not indicate the purpose for the call. The notes lacked any description of the events on 5/20/16, as reported by F-C, including fluid weeping from her legs and F-C's report to the nursing staff. The record also lacked any on going tracking of the level of edema and/or fluid weeping from the legs after 5/20/16. However, NP-A did discontinue the sodium pill, wrote orders to keep resident in bed	F 157		

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F 157	Continued From page 4	F 157		

with lower extremities elevated, and increased a medication to help relieve fluid build up.

NP-A's visit note of 5/20/16 indicated R31 was seen for a change of condition. R31 was in reclining chair alert only to stimuli which was a significant change to previous level of consciousness. R31's legs were swollen, but not pitting, weeping moderate amounts of fluid. The note indicated F-C had reported R31 said she "was 'ready to die.'"

On 5/26/16, at 2:10 p.m. RN-C reported regarding R31, "If her legs are down they will swell up."

NP-A was interviewed on 5/31/16, at 12:30 p.m. and explained the events of 5/20/15. NP-A stated F-C found R31 with swollen legs and fluid weeping from the legs. NP-A made a visit that day and found the resident's significant change in condition. Medication was increased to remove excess fluid with good results and R31 had since been more alert. NP-A stated every time she saw R31 she had edema and although it was not documented, would have been surprised the edema was not present at the time of the resident's admission to the facility. When asked about administering sodium when edema was present NP-A verified it could have worsened the edema, but she had been more concerned with the low sodium levels. NP-A verified she had not notified the MD about R31's weeping legs and she had discontinued the sodium.

On 6/1/16, at 10:00 a.m. the primary MD was interviewed. She verified the sodium could have contributed to edema and said, "It now makes more sense now about her drastic change in her legs with the extra sodium." The MD also verified

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F 157	Continued From page 5 R31's sodium levels could have been low due to her diagnosis of congestive heart failure with edema. The facility's 7/15, Notification of Resident Change in Condition policy indicated "facility clinicians will immediately inform the physician and resident's legal representative when there is a significant change in physical, mental, or psychosocial status." Documentation was to be completed in the nursing progress notes the time notification was given.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who self-administered medications were assessed as safe to do so for 2 of 2 residents (R90, R45) who were observed self-administering medications. Findings include: R90 was interviewed on 5/26/16, at 10:34 a.m. The resident's breakfast tray was on his bedside table. The surveyor offered to return at a later time since the resident had not yet eaten, however, the resident chose to talk to the surveyor instead. As the resident talked, he opened a package of Arginaid (supplement to	F 176	1. R90 and R45 were assessed for a self administration of medication and updated care plan. 2. Residents that reside at PHRC have the potential to be at risk of this practice. 3. Licensed Nurses have been re-educated related to the facilities policies and procedures on self-administration and medication administration. 4. DON/Designee audits 5 charts and observe medication administration for 4 weeks, then 2 charts and medication administration weekly x 3 months 5. DON/Designee will forward results of	7/11/16

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F 176	Continued From page 6 promote wound healing) and poured it into a glass of juice. A soufflé cup containing two pills and one capsule was also on the bedside table. When asked if staff usually left his pills for him to take later the resident explained, "they have to" because he would feel sick to his stomach if he did not eat something prior to taking the medication. An assessment indicating R90 was deemed safe to self-administer medications was not located in the resident's medical record. The interim director of nursing (IDON) was informed of the observation on 5/26/16, at 1:39 p.m. She also looked in the resident's medical record and confirmed, "I don't see one in here either. I'm not finding it." At 1:49 p.m. the IDON reported, "I talked to the nurse," who had explained the resident requested a gauze bandage, and she left the room to get it for the resident. When she returned she thought the resident had taken the medications. The IDON reported she had educated the nurse that she needed to ensure residents actually took their medications prior to leaving the room. When asked whether R90 would have been a candidate for self-administering medications the IDON replied, "yes," and said the nurse manager agreed he likely could have safely taken his medications and she would complete a self-administration assessment. On 5/26/16, at 7:28 a.m. a trained medication assistant (TMA)-A walked in and out of various resident rooms while passing medications and answering call lights. R45 was then interviewed at 7:33 a.m. A	F 176	self medication assessments and medication administration to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11, 2016.	

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F 176	Continued From page 7	F 176		

medication cup was observed on the resident's bedside table. The cup appeared to contain pudding or applesauce with crushed medication and a plastic spoon. A second medication cup containing liquid was also on the table. R45 explained, "The staff usually just leave the medication here and I wait until my husband comes in to take them."

At 7:51 a.m. TMA-A was interviewed and stated she had not given R45 her medications that morning, as R45 usually waited until her husband came before taking the medications. TMA-A verified she had left medications in R45's room, but later removed them until R45's husband arrived. TMA-A further acknowledged stated she was aware of the facility's medication administration policies and stated, "I thought she [R45] was care planned to have her medication left at bedside."

When the surveyor returned to R45's room at 7:58 a.m. the two cups of medication were no longer on the resident's bedside table. At that time R45 confirmed she had not received her medication yet and again explained she was waiting for her husband to arrive.

RN-C was interviewed at 7:59 a.m. and confirmed R45 had not been assessed as safe to self-administer her own medications and stated, "You don't even have to look on her care plan--it will not be there." RN-C further stated she had expected medications to be in the nursing staff's sight at all times until taken and verified no medication should have been left in the resident's room unless it was being administered at that time.

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F 176	Continued From page 8 The facility's 7/15, Self-Medication Assessment and Management policy indicated the purpose was to evaluate a resident's ability to self-medicate safely. The procedure gave step by step instructions to determine whether a resident was able to self-administer medication safely. Staff were instructed to: "1) Complete the 'Self-Medication Data Collection and Assessment' form for resident being evaluated for self-medication administration. 2) Review and analyze the assessments to determine the resident's ability to self-medicate and review with the interdisciplinary team. 3) Consult with the pharmacy of how the self-administration is going to be in place for each resident. 4) Discuss with the physician which medications are or are not going to be self-administered by the resident. 5) Document in nursing notes that resident is able to self-administer medication safely."	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		7/11/16

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F 225	Continued From page 9 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse to the State agency (SA) immediately for 1 of 4 residents (R12) reviewed for an injury due to an unwitnessed fall. Findings include: The occurrence log dated 5/2/16, indicated R12 had a fall at 5:05 a.m. The report noted R12 "fell to the ground." The untitled sheet which contained a column for Office of Health Complaints (OHFC) project number sheet was reviewed for entries on 5/2/16, and R12's fall was not called in to OHFC. The Common Entry Point (CEP) Reporting Log was reviewed for the date of	F 225	1. Resident R12 no longer resides at the facility. 2. Residents that reside at PHR have the potential to be affected by this practice. Suspected vulnerable adult reports are reported to the appropriate state agency. 3. Staff have been re-educated on Policy and Procedure regarding vulnerable adults, accidents and incidents, as well as reporting obligations. 4. DON/Designee will review and audit all accidents, incidents, and allegations of abuse and neglect for appropriate reporting. 5. DON/Designee will forward results of all occurrences of accidents, incidents and	

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F 225	Continued From page 10 5/2/16, and no report was made to CEP on 5/2/16 regarding R12's fall. The Occurrence Report dated 5/2/16, noted R12 had a fall in his room. The activity indicated R12 was in the bed prior to the fall. The report depicted, "CNA [certified nursing assistant] found him on floor next to his bed on Left side, bed in low, he was throwing pillows at staff and being very unusual behavior. He had ripped off bandaides on the floor, hip drsg [dressing] almost off, heel drsg in place. Unable to tell if small areas bleeding were new or where he had ripped off bandaids. Area on left outer wrist replaced bandaide and a large drsy [sic] placed on Left side of head." The report reflected R12 had an excoriation area on the left side of his and the area of excoriation had no measurement. The section for Resident statement noted R12 to be "very confused per usual." The section for executive director and director of nursing to sign noted, "The IDT [interdisciplinary team] Met and reviewed the fall MD [medical doctor] notified and UA [urine analysis] ordered Care Plan Updated." The VOHRA (name of company) wound MD saw R12 in 5/4/16, and noted the wound measured 0.6 by 0.9 centimeters and there was light sero-sanguinous drainage. The intervention was to keep a clear occlusive dressing in place. The Prevention and reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property effective 7/15, described unknown injuries of unknown source as, "The source of the injury was not observed by any person or the resident could not explain the source of the injury," and "The injury is suspicious	F 225	allegations of abuse and neglect to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	

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F 225	Continued From page 11 because of the extent of the injury or the location of the injury or the number of injuries observed at a particular point in time, or the incidence of injuries over time." R12 fell on 5/2/16, and the fall was unwitnessed, R12 did receive an excoriation on the left side of his head, and the resident had altered mental status changes noted by staff on 5/2/16, and on 5/19/16. The facility did not report the unwitnessed fall to the appropriate State agency (ies).	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of potential neglect of supervision to the State agency (SA) immediately for 1 of 4 residents (R12) reviewed for an injury following an unwitnessed fall. Findings include: The facility's 7/15, Prevention and reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property described unknown injuries of unknown source as, "The source of the injury was not observed by any person or the resident could not explain the source of the injury...The injury is suspicious	F 226	1. R12 no longer resides at the facility 2. Residents that reside at PHR have the potential to be affected by this practice. Suspected vulnerable adult reports are reported to the appropriate state agency. 3. Staff have been re-educated on Policy and Procedure regarding vulnerable adults, accidents and incidents, as well as reporting obligations. 4. DON/Designee will forward results of all occurrences of accidents, incidents and allegations of abuse and neglect to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	7/11/16

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F 226	Continued From page 12	F 226		

because of the extent of the injury or the location of the injury or the number of injuries observed at a particular point in time, or the incidence of injuries over time." R12 experienced an unwitnessed fall on 5/2/16. The fall resulted in an excoriation on the left side of his head with altered mental status changes noted by staff on 5/2/16 and on 5/19/16. The facility did not report the unwitnessed fall to the SA.

The occurrence log dated 5/2/16, indicated R12 had a fall at 5:05 a.m. The report noted R12 "fell to the ground." The untitled sheet which contained a column for Office of Health Complaints (OHFC) project number sheet was reviewed for entries on 5/2/16, and R12's fall was not called in to OHFC. The Common Entry Point (CEP) Reporting Log was reviewed for the date of 5/2/16, and no report was made to CEP on 5/2/16 regarding R12's fall.

The Occurrence Report dated 5/2/16, noted R12 had a fall in his room. The activity indicated R12 was in the bed prior to the fall. The report depicted, "CNA [certified nursing assistant] found him on floor next to his bed on Left side, bed in low, he was throwing pillows at staff and being very unusual behavior. He had ripped off bandaides on the floor, hip drsg [dressing] almost off, heel drsg in place. Unable to tell if small areas bleeding were new or where he had ripped off bandaids. Area on left outer wrist replaced bandaide and a large drsy [sic] placed on Left side of head." The report reflected R12 had an excoriation area on the left side of his head that was not measured. The section for resident statement noted R12 to be "very confused per usual." The section for executive director and director of nursing to sign noted, "The IDT

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F 226	Continued From page 13 [interdisciplinary team] Met and reviewed the fall MD [medical doctor] notified and UA [urine analysis] ordered Care Plan Updated." The VOHRA (company name) wound MD saw R12 on 5/4/16, and noted the wound measured 0.6 by 0.9 centimeters and there was light sero-sanguinous drainage. The intervention was to keep a clear occlusive dressing in place.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clothing was changed appropriately for 1 of 3 residents (R72) reviewed for dignity. Findings include: R72 was observed on 5/23/16, at 3:00 p.m. wearing a shirt with a button missing in the middle portion of the chest and was not wearing an undershirt. R72 was then observed wearing the same shirt the next day. On 5/25/16, at 7:26 a.m. R72 was observed getting up from bed for the day with the help of two nursing assistants (NAs). R72 was wearing the same shirt as he had worn the past two days. NA-S recognized R72 had worn the shirt the day before and helped the resident to change into a clean shirt.	F 241	R72 shirt was changed and resident continues to be offered and given support with care and activities of daily living in accordance with his Care Plan. 2. Resident that resides at PHR have the potential to be affected by this practice. Residents at PHR are offered and given care per their Care plans. 3. Staff have been educated on providing dignified care to residents in accordance of their Plan of Care. 4. DON/Designee will conduct audits 3 x per week, then monthly x 3 months on cares being provided per individualized Plan of Care in a dignified manner, including appropriate clothing. 5. DON/Designee will forward results of all care audits to the QAPI committee	7/11/16

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F 241	Continued From page 14 On 5/26/16 at 3:00 p.m. a registered nurse (RN)-C responded, "That is not acceptable" when told R72 had worn the same clothing for at least two days and slept in the shirt, as well. The facility's 7/15, Personal Needs policy indicated residents would be given needed support with activities of daily living according to their care plan.	F 241	monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to offer bathing preferences to 1 of 3 residents (R42) reviewed for choices. Findings include: R42 was interviewed on 5/23/16 (a Monday), at 5:19 p.m. R42 stated she was scheduled to receive a shower on Wednesdays however, had not received a shower the previous Wednesday (5/18/16). R42 said staff had instead offered to give her a bed bath. R42 also stated she preferred a shower more than weekly, but had	F 242	1. R42 was interviewed for bathing preference and care plan has been updated. 2. Residents that reside at PHR have the potential to be affected by this practice. Resident interviews have been completed and Care Plans have been updated in regards to resident bathing preference. Residents are interviewed upon admission, quarterly and as needed regarding bathing preferences. Resident preferences are also reviewed at care conferences. Care plans have been updated to reflect resident choice for	7/11/16

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F 242	Continued From page 15 been unable to receive more frequent showering. On 5/25/16, at 9:01 a.m. R42 re-stated she would prefer to have two showers weekly, but did not think it was possible. R42 stated she had not been previously asked by the facility how often she would like to bathe, and reiterated it would be nice to shower twice a week. At 9:43 a.m. on 5/25/16, a trained medication assistant (TMA)-A explained that residents typically received one shower weekly, unless the resident requested more frequent bathing. It was then added to that resident's care plan. TMA-A said she was unaware R42 wanted a second shower. During an with interview with a registered nurse (RN)-C on 5/27/16, at 10:19 a.m. she stated bathing preferences had not been discussed at resident care conferences. RN-C stated R42's shower schedule would be changed to twice weekly. RN-C also stated R42 had an appointment Wednesday mornings, therefore the day of the week also needed to be changed.	F 242	bathing. 3. Staff have been educated on providing choices to residents in regards to bathing and in accordance of their Plan of Care. 4. DON/Designee will conduct audits 3x per week, then monthly x 3 months on bathing preference being provided to the residents per individualized Plan of Care. 5. DON/Designee will forward results of all care audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the	F 250	1. R57 no longer resides at the facility.	7/11/16

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F 250	Continued From page 16 facility failed to provide medically related social services to ensure comprehensive discharge planning for 3 of 3 residents (R57, R90, R72) whose discharge planning was reviewed. In addition the facility failed to utilize de-escalation techniques to diffuse a situation for 1 of 1 resident (R19) who was charged with Disorderly Conduct. Findings include: R57 had a history of failed discharges to home, including from the facility on 1/28/16, followed by hospitalizations. R57's hospital admission dated 10/17/15, indicated R57 was in her mid-50's, and had multiple co-morbidities including intractable back pain, neurogenic bladder, diabetes, chronic pain syndrome, anxiety, and was wheelchair dependent. The resident had been discharged from the hospital at 9:00 p.m. but was unable to get out of the car. She was admitted for observation and was agreeable to going to a transitional care unit (TCU), but would be unable to pay for it. The admission note indicated the resident was not in a situation to be discharged. It was noted the resident had "multiple TCU stays with failed Discharge to home yesterday." A social work note also dated 10/17/16, revealed options would be reviewed with the resident and her family. "Would benefit from increased services upon discharge." R57 was then admitted from the hospital to the facility. An occupational therapy (OT) assessment dated OT assessment 10/21/15, noted the resident lived alone, but utilized numerous assistive devices (e.g. slide board, grab bars) and equipment (e.g. hospital adjustable bed), as well	F 250	R19 Care Plans have been reviewed and updated with interventions to meet his psychosocial needs. R90 and R72 have had care conferences to discuss discharge planning and Care Plans have been updated. 2. Resident that resides at PHR have the potential to be affected by this practice. Residents have had care conferences to discuss discharge planning as appropriate. Resident's with target behaviors have been reviewed for appropriate interventions and Care Plans have been updated. 3. Social Service and Nursing have been educated on discharge planning. Staff have been educated on interventions for escalating behaviors. 4, DON/Designee will conduct audits 3x/week x 4 weeks, then 3x per month x 3 months on behavioral care plans on residents that have exhibited behaviors. In addition the Social worker/Designee will audit 3 charts per week x 4 weeks, then 3 x per month to ensure residents hav a discharge plan of care in place. 5. DON/Designee will forward results of all behaviorial care plans and discharge care plan audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	

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as public transportation, and had a supportive family. "Assessment: medically complex resident presents with decreased indep in ADLs [activities of daily living], self care, now requires max assist for functional tasks weakness in UEs [upper extremities], impaired endurance and coordination. Skilled OT medically necessary to improve indep safety in ADL for safe discharge home. "Pt would not be able to return home safely at this time." An OT d/c note 1/26/16, Pt actively participated in OT sessions and made good progress toward goals. Pt is discharging at indep [independent] level for toileting and transfers. CGA [contact guard assist] for tub transfers and not more than minimal assist for bathing tasks. Improved standing IADL assist for cleaning and meals. Nursing for med admin and IV meds [intravenous medications]...Pt is discharging with increased indep in ADLs, transfer resulting from functional improvement/performance."

A care conference (CC) summary on 10/23/15, indicated the resident's expected stay was eight weeks, as she was de-conditioned from hospital stays.

A 10/23/16, LSW Progress Notes indicated R57's the length of stay was estimated at eight weeks. On 12/4/16 the LSW contacted Washington County "for private duty." On 12/10 multiple calls were made to Washington county to verify private duty. 12/23/15, Contacted Hennepin County to follow up on PCA (personal care assistant) assessment. They sent case back to Washington County and case worker did not answer the phone.

Physician notes dated 12/21/15, indicated the

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physician was attempting to decrease the resident's pain medications and documented concerns about multiple medications (various narcotics, anti-anxiety and hypnotics) and scripts from various providers, as well as not following through with a psychological referral. After last week's visits and adjustments pt called 911 and went to ER. No changes or meds were given. Pt seen last week to discuss concerns about med use. "Per staff will be d/c [discharged] soon. She appealed her original d/c x 2 so SW unsure of date. Plan to slowly titrate meds safely and effectively and SW will discuss options for counseling throughout process. Will be d/c with only a few days of narcotics and will need to f/u [follow up] with pain dr to help manage. SW looking into pain contract to avoid multiple prescribers." On 1/20/16, the physician noted the resident was being managed at a pain clinic, the resident had a psychological appointment scheduled, and had been experiencing urinary tract infections (UTIs).

The care plan for R57 dated 10/15 and updated 1/16, noted the plan was for the resident to stay short term, and she required assistance with discharge planning. The d/c goal read, "Be discharged to least restrictive and safest setting with home care assistance when appropriate." The staff was to discuss d/c with resident/family and update on progress. Assist with need for health services prior to d/c community resources, equipment, home health, home assessment as needed, plan a family meeting as needed." In addition, on 10/26/15 UTI was added to the care plan, and 11/9/15 a handwritten note "recurrent."

A physician discharge summary dated 2/3/26, indicated Final Diagnosis: intractable back pain;

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F 250	Continued From page 19 Prognosis: fair; Rehab potential: fair. A CC summary dated 12/4/15, indicated the resident's current status was stand-by assistance/supervision with slide board transfers. The planned time frame for discharge was 12/9/15. "Family and res [resident] had billing questions and business office answered those questions. SS [social services] set up with Fairview Home care with services of OT, PT, RN set up and HHA [home health aide]. SS has contacted Washington County for private duty." On 12/10 SS has attempted multiple times to contact Wash [Washington] county to verify services for private duty." Although the reason was not noted, the LSW contacted eight nursing homes per the "resident's request" between 12/11 and 12/22/15. On 12/23 the LSW discussed d/c and contacted Hennepin County to follow up on need for PCA. That county sent the referral to Washington County, so LSW left the case worker a message. The therapy end date was planned for 1/26/16. "Barriers are resident is unclear with current level of function due to residents manipulation and behaviors fluctuating assistance with needs. Res agreed to d/c from the facility on 1/27 with the following processes above. Continue to monitor and follow up as needed." On 1/29/16 "Discharge Plan Review: To Discharge home w/ services." Fairview Home care also Fairview infusion for abx [antibiotics],"Other: Also made referral to Visiting Angels." LSW note 1/21/16, "Res has 10 hours a day for PCA [personal care attendant] services through her waiver with skilled services from Fairview home care." The occupational therapy/registered (OTR) was interviewed on 5/26/16, at 8:47 a.m. The OTR	F 250		

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said the resident utilized a lot of equipment, and was independent in transfers with the use of equipment. She said OT "picked her back up that second time to be sure" the resident was ready for discharge, and described it as a "high focus case that we were all very involved in." R57 informed the therapist she was unable to complete independent transfers "and was tearful and really didn't want to go home. Some things came up and we had to look at little deeper such as her medications and dependence worked with the NP [nurse practitioner] and it was a group effort." The plan was for the resident to have OT, bathing, a nurse for IV meds, cleaning, cooking although she was able to perform light meal preparation and light cleaning tasks.

R57's Progress Notes included the following:
1) 1/7/16 antibiotic ordered for throat infection
2) 1/19/16, Resident has a staph sinus infection
3) 1/27/16, resident had a emesis at 7:00 and 9:30 p.m.
4) 1/28/16, at 5:00 a.m. no distress for pain and at 10:30 a.m. R57 discharged home.
5) 1/29/16, "To discharge home [with] services."

A "Discharge Notice: 1/27/26, Services: Private Duty PCA, HHA [home health aide], RN med set up, PT, and OT, and SW. Agency: Fairview Home Care. Social Service Discharge Summary 1/28/16 Agency: Fairview Home Care also Fairview infusion for antibiotic. Other: Also made a referral to Visiting Angels."

On 5/26/16, at 9:00 a.m. the administrator was interviewed and said a private duty PCA was previously Visiting Angels and the LSW here gave the referral to Visiting Angels. The LSW wrote an extensive discharge note in her record. "I believe

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she had some behavioral issues where she'd say she couldn't transfer but could do it just fine in therapies."

R57 was interviewed by telephone on 5/27/16, at 9:10 a.m. The resident reported she did not feel she had appropriate discharge planning and coordination of services when discharged from the facility. She said she had been in and out of the hospital and was currently in the hospital again. R57 stated, "I only agreed to go home because of insurance. They were making it mandatory for me to come up with the money." She had a UTI that she had been trying to get treated since about 11/15, as well as a throat infection. R57 alleged when she left the facility although she was able to transfer into bed, she was unable to get out of bed without help, which was why she needed the PCA. The resident explained she was "quite ill when they discharged me" due to the UTI. PCA services were supposed to be arranged prior to her discharge, but said, "No they didn't have it set up right away so I had to wait three weeks." R57 said she did have some help from the facility social work help, "but I didn't feel like they were very proactive on my account...It didn't seem things were coordinated between the nurses and SW's. Nursing wasn't communicating with them and my labs were abnormal and a positive UTI and I kept asking them why I was not being treated." She reported she had seen an otolaryngologist as she was having throat issues as well.

A registered nurse clinical coordinator (RNCC) from Fairview Home Care was interviewed on 5/31/16, at 9:20 a.m. RNCC reported they had received a referral on 1/27 for services ending 1/27/16. She explained the resident was

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"supposed to go home, but was throwing up," so the following evening on 1/28/16, they received notification the resident was "on her way home," and discussion surrounded the need for antibiotics "which she was supposed to get at facility but didn't as they were 'all out.'" RNCC said the agency did not provide PCA services, but she did have an aide on February 1, 3, 10, 23, and March 2, 12, 17, 23, 29, and 30/16. R57 was also receiving OT and PT services. A LSW saw her on 2/9/16, and noted the resident was "homebound due to weakness...health worsened." The Community Access for Disability Inclusion (CADI, which provided funding for home and community based services) worker at the county was supposed to see her, but had not shown up for several days. R57's sister and nephew were checking in on her on the weekend, but worked during the week. The LSW wrote that it was "unsafe for pt to be home at this time."The LSW supplied information, discussed, and called adult protection together to report "how this was an unsafe discharge" from the facility. RNCC stated, "I feel if the county would've gotten out to see her quicker it would be been a better scenario."

The administrator of record (AOR) was interviewed on 5/31/16, at 10:57 a.m. and reviewed R57's financial file with the surveyor. She stated the billing file dated 10/22/16, revealed the resident's stay was not covered by workman's compensation which the resident was told. The resident was required to compete a spend down for Medicaid, then contribute her income to her stay minus $97 a month. The AOR said paperwork went back and forth between Hennepin and Washington County. In addition the paperwork showed there was no need for skilled

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services according to the fiscal intermediary.

On 6/20/16, at approximately 2:00 p.m. the ombudsman assigned to the facility reported he had been told by previous staff did not need his help resolving issues. When surveyors informed him of some of the resident's concerns and work with relocation services, he said there were additional services available if the relocation service could not find alternative housing for a resident. He said he had asked the staff why they did not ask for his help with cases of non-payment, and said he could have been helping them to resolve the issues. The ombudsman reported he planned to return for the next several days to meet with individual residents and staff. The ombudsman said he briefly met with R19, and obtained a copy of a police report involving the resident and staff.

R19 was yelling and swearing at a registered nurse (RN)-H which led to a Disorderly Conduct citation by police, however, documentation regarding the incident did not reflect staff utilized techniques to diffuse the situation.

A St. Louis Park Police Department report dated 3/12/16, at 8:52 p.m. revealed officers were dispatched to the facility for a disturbance. The victim was identified as RN-H who stated "there was a patient who was 'being loud and cursing in the hallway." RN-H described the conversation and stated she was "offended by the language [R19] used and wanted him charged with disorderly conduct. [RN-H] completed a Citizen's Arrest form which is attached to this report." The officer also spoke to R19 who reported RN-H "yelled at him for no apparent reason, was standing over him in his personal space pointing

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her finger at him, and he felt trapped. Out of fear for his safety he swore at the RN-H to get her away from him. R19 said another resident was with him at the time. The officer spoke to this resident as well, who reported they may have been too loud, and the RN-H did get too close to R19 as she continued to yell. The conclusion read, "I issued a citation to [R19] for Disorderly Conduct. [R19] stated he wanted to pursue threats charges against [RN-H] because he was a vulnerable adult. I asked both [R19's name vs RN-H] and other nursing staff if [R19] was deemed a vulnerable adult by the state. They each stated he was not. At the time of this report being written, I did not find grounds to bring threats charges against [RN-H]. "

The accompanying witness statements included: The ED on 3/14/16 who noted she received a call from RN-H who reported R19 was yelling out of control and using inappropriate language, which the ED could hear in the background. "RN-H said she was going to call police because there was nothing she could do or say to settle him down. She said resident was talking too loud outside other resident rooms and the resident was complaining for [sic] the noise." The ED spoke to the resident who reported the RN-H had him out in the hallway with the vending machines and was pointing her finger at him and telling him to be quiet. He said he became loud and started yelling. "He feels like the RN-H owes him an apology." The RN-H said she may have been using hand gestures but did not lean over him and point her finger at him.

The resident with R19 explained on 3/14/15, staff were getting residents ready for bed, but it was not "'super late.'" The RN-H informed the two

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residents they were being too loud. [R19] responded, "'okay'" but RN-H "then got 'up in [R19's] face and said you need to move. [R19] responded by saying 'I said okay! And you don't need to talk to me like that." R19 began swearing and RN-H went and called the police. The resident "reports that he feels 'the RN-H blew it out of proportion.'"

A housekeeper witness statement dated 3/20/16, indicated the RN-H asked the resident who was taking too loud to be quiet and he got pretty angry and refused so it "quickly escalated, but the resident wasn't physically inappropriate. "

The ED's conclusion dated 3/14/16, "Investigation report: See attached statements and police report filed by RN-H on duty-witness statements. Resolution and disposition: After reviewing the police report and witness statements writer spoke with resident regarding inappropriate interaction and approach [with] staff and other residents. Also spoke to him about noise and other residents' rights within the center. "

The executive director (ED) and a licensed social worker (LSW)-B were interviewed on 5/25/16, at 2:26 p.m. The ED reported she received a phone call from a pool RN-H who described R19 "'out of control, swearing, causing a big ruckus.' She said she needed to call the police and I told her 'okay.'" The ED said on a previous occasion the police were called when R19 was throwing things around and was yelling and the police said they could not take the resident in [to the police station]. Another time the resident was heard saying "he was going to 'get a gun and shoot up the place,'" The police were notified and did not think it was a serious threat. The ED said they

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had witnesses who reported he was loud on the evening in question. The ED said she had not seen nor obtained a copy of the police report. The ED and LSW-B were told staff had informed the officers R19 was not a vulnerable adult, therefore the officer charged the resident with disorderly conduct the ED stated, "Everyone in our facility is a vulnerable adult. She [pool RN-H] would have been trained and I can give you the packet. If she said that, that is absolutely not the correct answer." All staff received annual abuse training and staff were trained in how to de-escalate a situation during dementia training according to the ED. The ED explained R19 was young and wanted to get into a different housing situation, and had outstanding bills at the facility and other issues that needed to be cleared up. They had not utilized the ombudsman to assist with these issues. LSW-B requested information regarding additional available resources when the relocation service was unable to find alternate housing options for a resident.

RN-H's orientation checklist dated 2/25/16, indicated abuse and Resident Bill of Rights training was provided. The files of the three staff who worked on the unit the evening of 3/14/16, revealed evidence abuse training had been completed in the past year.

The facility's 7/1/15, Behavior Management: Managing Behaviors and Documentation instruction guide. The guide noted key points to remember when dealing with residents who had mental illness or a behavior issue which included, "Our residents are...People not to argue with; the reason why we're here...." Examples of verbal behaviors included "cursing, false accusations, sexual language, and yelling...For residents who

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expressed anger and agitation, these are some interventions that work well: Provide a safe environment and if anger escalates, keep all residents safe; Calm the situation and do not argue with the resident...."

LSW-B said she was unaware of additional services beyond relocation services, and requested the resource information.

R72's family member (F)-A reported in an interview on 5/24/16, at 9:01 a.m. he wanted the resident moved to the Minnesota Veteran's Home Minneapolis, however, paperwork sent by the Veteran's Administration (VA) staff to the facility had not been returned. F-A said the paperwork had been sent by the VA to the facility on 5/13/16, but they had not received a reply from the facility, "and he can't be admitted without it." F-1 reportedly spoke to someone "last Tuesday and she said she would look into it," and he provided they phone number of the intake worker.

A letter requesting information was dated and faxed to the facility 5/13/16. The letter had a hand written note dated 5/20/16, that read "waiting for MDS information then can send." The medical records manager stated on 5/25/16, at 3:30 p.m. she had been waiting for the resident's Minimum Data Set (MDS) to be completed, before sending the requested information to the potential facility where the resident wished to be transferred. She explained, "I sent it now." When asked why the fax date was 5/13/16, but the received date was handwritten 5/20/16, the medical records manager explained, "Because that's the date I received it," and it the delay was "because of our problem with social workers."

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R90 reported in an interview on 5/24/16, in the afternoon, he did not feel the staff involved him in decisions about his care rather, the staff do what they wanted to do and it was not the way the resident preferred things done.

In a follow up interview on 5/26/16, at 10:34 a.m. with R90 he stated, "It's not the place to stay cuz this not a residence and they treat you like that. They're always saying something that prevents you from moving ahead." He denied being involved in decisions about his care and life at the facility, and stated, "I don't necessarily see that happening here." He stated he wanted to live in St. Paul, but lacked the resources to move. He named numerous outside persons had or were trying to assisting him. R90 stated regarding facility staff, "They can only give you a small part of their attention because they have other places." When asked whether anyone at the facility was advocating for him he asked, "Do you mean like a social worker?" He responded that he had little interaction with a social worker at the facility.

A hospital history and physical dated 3/9/16, indicated R90 was in his mid-50's and had issues including homelessness after eviction from his apartment, cognitive delay, as well as diabetes and difficulty caring for foot wounds which he had been dressing with rags and note cards. The hospital discharge summary dated 3/10/16, indicated diagnoses including diabetes, adjustment disorder with mixed anxiety and depressed mood, possibly undiagnosed psychiatric disorder.

R90's social service section of his record contained a room change form, mental status

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F 250	Continued From page 29 assessment, admission/discharge evaluation that indicated the goal was fewer than 30 days stay (referred to relocation services) and a Life Enrichment assessment by recreation therapy staff. There were no social service progress notes or care conference summaries. RN-B looked in the social service section of the record and verified on 5/26/16, at 1:22 p.m. "Yeah, it looks like he didn't have a conference based on that" (her inability to also locate information in the social service section of the resident's record).	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		7/11/16

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F 279	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop an individualized comprehensive care plan related to the use of an indwelling catheter for 1 of 2 residents (R96) reviewed for catheter use. Findings include: R96 stated during an interview on 5/25/16, at 10:03 a.m. that although he was able to void on his own when he was first admitted to the facilty, within a few weeks, "I was all plugged up. Because of this the resident explained, ""I was not able to urinate, so the facilty put in a catheter, which the resident had continued using. R96 stated he unsure what the future plan was regarding the use of the catheter, nor was he sure whether he had seen a urologist regarding the problem. R96's admission Minimum Data Set Dated 5/13/16, indicated the resident had intact cognition, a Foley catheter was not in use, and the resident required supervision and cueing for toileting needs. R96's active diagnoses included anemia, depression and diabetes mellitus. R96's care plan dated 5/9/16, did not include problem identification, goals, and interventions for caring for the Foley catheter. On 5/25/16, at 10:53 a.m. a licensed practical nurse (LPN)-B stated R96 was admitted from the emergency room with a diagnosis of urinary retention. LPN-B explained R96 was able to void urine for a few days then required straight catheterization regularly unit a Foley catheter	F 279	1, F96 no longer resides at the facility. 2. Residents that reside at PHR that have a catheter have the potential to be affected by this practice. Residents with catheters were reviewed to assure that individualized Care Plan were developed to reflect use of the catheter. 3. Staff that are responsible for the development and revision of Care Plans have been educated. 4.DON/Designee will conduct audits 1 x per week x 4 weeks, then 3 x per month to assure appropriate catheter Care Plans have been completed. 5. DON/Designee will forward results of all catheter care plan audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	

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F 279	Continued From page 31 order was received. LPN-B was unsure whether R96 was to see a urologist. R96's nurse practitioner (NP) notes dated 5/17/16, indicated the resident was having episodes of urine retention and a Foley catheter was ordered with a trial removal "in a few days or next week" and if unable to void independently "refer to urologist." During an interview on 5/25/16, at 2:56 p.m. a registered nurse (RN)-C verified R96's care plan did not reflect the use of an indwelling catheter. RN-C verified the care plan should have indicated the size, type, as well as instructions should the catheter became dislodged or was not patent. RN-C explained the nursing staff utilized the Lippincott Manual of Nursing edition eight, for standards of nursing practice. The facility's 7/15, Care Plans policy indicated care plans were used to identify resident's issues, measure objectives timely, describe the services to be provided and to maintain the resident's highest practicable physical, mental and psychosocial well-being.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		7/11/16

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F 280	Continued From page 32 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure care conferences were held as required and failed to ensure residents and/or their representatives were provided the opportunity to attend the conferences for 7 of 19 residents (R90, R72, R8, R19, R62, R45, R42) reviewed in stage II of the survey. Findings include: R90 was interviewed on 5/23/16, at 3:09 p.m. When asked during standard questioning whether he felt he was involved in decisions about his care at the facility R90 replied, "The staff do what they want and it's not the way I want it." In addition, the resident reported numerous health concerns including unhealed wounds as well as psychosocial concerns such as a desire to move to another setting. In a follow up interview on 5/26/16, at 10:34 a.m. R90 again denied being involved in decisions about his care and life at the facility stating, "I don't necessarily see that happening here." The	F 280	1. R90, R72, R8, R19, R62, R45 and R42 have all had care conferences. 2. Residents that reside at PHR have the potential to be affected by this practice. Residents have been provided the opportunity along with their representatives to participate in Care Conferences. 3, The Interdisciplinary Team has been educated in regards to the attendance of the resident/ and or the resident's representatives to participate in care conferences. The Director of Social Service has been educated on the Care conference Policy and Procedure. 4. Executive Director/designee will audit 3 Care Conferences x 4 weeks and then 3 x per month to assure quality meetings are being held with the participation of the IDT. 5. Executive Director/Designee will forward results of Care Conference audits to the QAPI committee monthly x 3 months for continued opportunities for	

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F 280	Continued From page 33 resident stated he felt the physicians were "absentee." He reported a desire to move to St. Paul, but said he lacked the resources to move. In addition, he stated that although various outside persons had been or were assisting him to move, he did not feel anyone from the facilty was advocating on his behalf. R90 stated (regarding the facility staff), "They can only give you a small part of their attention because they have other places--it's cost effective." A hospital history and physical dated 3/9/16, indicated R90 was in his mid-50's and had issues including homelessness after eviction from his apartment, cognitive delay, as well as diabetes and difficulty caring for foot wounds. The hospital discharge summary dated 3/10/16, indicated diagnoses including diabetes, adjustment disorder with mixed anxiety and depressed mood, possibly undiagnosed psychiatric disorder. The social services section of R90's medical record lacked information reflecting an initial care conference had ever been held. The social service section of his record contained a room change form, mental status assessment, admission/discharge evaluation that indicated the goal was fewer than 30 days stay (referred to relocation services), and a Life Enrichment assessment by recreation therapy staff. There were no social service progress notes or care conference summaries. A registered nurse (RN)-B looked in the social service section of the record on 5/26/16, at 1:22 p.m. and verified she was unable to locate information regarding a care conference having being held. RN-B stated, "Yeah, it looks like he didn't have a conference based on that."	F 280	quality improvements. 6.	

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R72's medical record revealed the most recent admission was in 11/15. The social service section of the resident's record, however, lacked evidence a care conference had been held for the resident and his family as required.

On 5/26/16, at 1:22 p.m. RN-B verified if there was no note in the social services section of the resident's record, he did not have a conference held.

R8 was admitted to the facility on 12/11/12. Her quarterly MDS assessments were completed on 12/7/15 and 2/17/16. Although Social Worker Progress Notes were written on 9/8/15 and 12/8/15, the documents lacked evidence that a care conference was conducted on her behalf or that she or her representatives had been notified or invited to attend a care conference meeting. In addition, a review of R8's progress notes related to social services, dated 2/26/16 through present, lacked evidence of a care conference meeting.

R19 was admitted to the facility on 12/10/15. An admission MDS was completed on 12/17/15 and a significant change MDS was completed on 2/29/16. A review of R19's progress notes related to social services dated 12/22/15 and 1/14/16, indicated care conferences had been completed on these dates. However, documented evidence was lacking to indicate whether a care conference meeting had been set-up and completed following a significant change MDS dated 2/29/16.

R62 was admitted to the facility on 12/3/15. An admission MDS was completed on 12/9/15 and a quarterly MDS was completed on 3/10/16. Upon

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review of R62's record, it was determined a care conference had been conducted on 1/7/16 (greater than 21 days from her admission), and the record lacked evidence of any further care conference meetings for R62.

On 3/30/16, at 1:32 p.m. RN-E stated she had spoken to licensed social worker (LSW)-A who verified care conferences had not been held, or were not held in a timely manner, for R8, R19 or R62. RN-E said LSW-A had stated, "If it doesn't say it was done, then it wasn't."

R45 was admitted to the facility on 6/18/15, and her medical record was reviewed on 5/31/16. R45's record lacked documentation the resident and/or her representative were offered the opportunity to attend a care conference nor was there any evidence a care conference had been held on her behalf.

LSW-A stated during interview on 5/31/16 at 9:05 a.m. that she was new to her social work position, but was aware care conferences for residents were not being routinely held. LSW-A verified residents should have a care conference held during the following time frames: initial conference before the 21st day of admission, quarterly, annually and with any significant change.

On 5/31/16 at 9:20 a.m. the interim administrator verified R45 has not had a care conference since admission, but now had one scheduled for 6/7/16.

R42 stated during interview on 5/23/16, at 5:24 p.m. she did not feel the facility included her in decision making regarding her medications,

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therapies or other treatments, but would like to be included. R42 pointed to her nebulizer machine and stated she had recently been started on nebulizer treatments, yet had not been informed as to the reason. R42 also stated she had not yet had a care conference since her admission in December 2015.

On 5/26/16, at 8:25 a.m. RN-C verified there were no care conference notes in R42's chart and that she had not been involved in any care conferences for R42.

At 9:20 a.m. LSW-B stated she and the other agency social workers were presently just working on discharges and care conferences for those residents who were living here temporarily and who had plans for leaving. LSW-B verified she was aware residents at the facility had not had care conferences held, even back as far as a year ago. LSW-B further stated she had been involved in any care conference for R42.

On 5/26/16, at 12:38 p.m. the interim director of nursing verified there had been no care conferences held for R42 since her admission to the facility.

The facility's 7/15, Resident/Family Conference policy indicated, "The center will encourage the resident and/or family/legal representative to attend the Resident Care Conference, which will be scheduled with the appropriate Interdisciplinary Team (IDT) members. The conferences will be scheduled based on identified needs and regulatory standards...Encourage the resident/family/responsible party to express their preferences about care. a. Respect and incorporate their preferences in the care

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F 280	Continued From page 37 decisions. 6. Summarize the outcome of the meeting and document attendance." The facility's policy for Care Plans dated 7/15, indicated a well developed care plan "Gives the Interdisciplinary team a common understanding of the resident" and "Reflects the resident/resident representative input and goals for healthcare." Staff were directed to involve the resident, resident's family and other resident representatives as appropriate.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure standard of nursing cares was provided for intravenous (IV) cares for 1 of 1 resident (R49) reviewed who utilized IV medication. Findings include: R49 was observed walking in the hallway at 8:15 a.m. on 5/25/16. The resident was observed to have a deflated (empty) IV infusion ball still attached to his peripherally inserted central catheter line (used to administer IV fluids or medications) in his upper arm. During the observation, R49 had a great amount of difficulty adjusting the empty infusion ball hanging down from his arm, and tried unsuccessfully on multiple occasions to tuck the infusion ball into his shirt	F 281	1. The nurses involved with R49's IV administration were educated upon notification. 2. Residents that reside at PHR that receive IV therapy have the potential to be affected by this practice. Resident that receive IV therapies Care Plans have been reviewed and updated as appropriate. 3. Licensed Nurses have been educated on following physician's orders as well as policy and procedure for all administrations of IV therapies. 4. DON/Designee will conduct audits of both the resident's plan of care and IV administration 2xper week x weeks and then 3 x per month x 3 months. 5. DON/Designee will forward results of IV	7/11/16

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F 281	Continued From page 38 pocket. During interview with R49 at 8:28 a.m. on 5/25/16, R49 reported as he pointed to the empty infusion ball, "This has been on since 2:00 p.m. yesterday [5/24/16] and I slept with it." R49 further explained, the nursing staff had not flushed the medication line when the antibiotic was finished running, nor had the nurse administered the second antibiotic (ceftriaxone) as ordered. A registered nurse (RN)-C was in the room while R49 explained the situation. RN-C checked the empty infusion ball and verified it was vancomycin from the previous day, just as R49 described. R49's medication administration record (MAR) for 5/16, indicated R49 was to receive ceftriaxone 2 milligrams (mg) infused intravenously at 100 milliliters (ml)/hour once daily at 6:00 p.m. and vancomycin 1500 mg once daily at 2:00 p.m. with normal saline (NS) flushes 10 ml before and after each IV dose. R49's MAR did not reflect staff initials indicating the antibiotic medications had been administered and normal saline flushes provided at 6:00 p.m. as ordered by the physician. R49's physician orders were to maintain his IV with the saline, antibiotic then saline (SAS) protocol. The same day at 8:26 a.m. a licensed practical nurse (LPN)-B verified he had not started R49's vancomycin that morning, and explained, "I only put his vancomycin on at 2:00 p.m. so that's when I will be doing it today." During an interview on 5/25/16, at 9:02 a.m. a nursing instructor (NI)-A and a nursing student (NS)-A caring for R49 that morning verified he was already dressed when they arrived at the	F 281	therapy Care Plan and IV Medication administration audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	

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facility around 6:35 a.m. Both verified R49 had the empty infusion ball of antibiotic still attached to his PICC line that morning when they arrived.

At 9:05 a.m. the interim director of nursing (IDON) then verified R49 was to received both antibiotics one at 2:00 p.m. and one at 6:00 p.m. but had not received the antibiotic of ceftriaxone nor the normal saline flush since the previous day, 5/24/16. The IDON stated the evening nurse was responsible for ensuring medication was administered as scheduled, and a medication error form would be filled out.

On 5/25/16, at 2:43 p.m. RN-D was interviewed by RN-C and the surveyor. RN-D verified she was the evening nurse responsible for administering medications to R49 on 5/24/16. RN-D reported she was aware the resident was prescribed two different IV antibiotics. RN-D explained R49 vancomycin had been started by the day staff. When she was in the resident's room she had time, so flushed the resident's tube with normal saline. "I noticed there was still some vancomycin antibiotic left in the infusion ball so after I flushed the PICC line I re-attached the antibiotic infusion ball to his [R49's] PICC line." RN-D verified she had not administered R49 his second antibiotic of ceftriaxone nor the normal saline flush at 6:00 p.m. RN-C then instructed RN-D she was to flush the tubing following the medication adminsitration and just prior to administering the second medicaiton.

RN-C stated she expected staff to follow the physician's orders and administer medications on time. RN-C stated the nursing staff was directed to use standards of nursing practice by referencing the Mosby's Medical Dictionary, 9th

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F 281	Continued From page 40 edition 2009, Elsevier and Lippincott Williams & Wilkins Manual Of Nursing Practice 8th edition which were available at the nursing station. The facilitiy's 3/16, Medication Administration policy directed licensed nurses/or trained medication aides to administer medications according to State specific regulation and follow the Six Rights of medication administration. A 7/15, Intravenous Medication policy directed staff to reference standards of practice in Lippincott's Nursing Drug Guide and Omnicare IV Nursing Manual.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 4 residents (R12) who was reviewed for changes in mental status after a fall for a resident who received Coumadin (blood thinner) and an antibiotic simultaneously, and had low oxygen saturation levels. Also, 2 of 3 residents (R8, R72) reviewed for pain. Findings include: R12's mood and behavior symptoms dated 9/11/15, respiratory care plan, and anticoagulant	F 282	1. R12 no longer resides at the facility. R8 and R12 have been re-assessed for pain and care plans have been updated as appropriate. 2. Residents that reside at Park Health and Rehabilitation who experience pain and or receive Coumadin/warfarin have the potential to be affected by this practice. Residents receiving Coumadin/warfarin have had a Care Plan review and physician notification with updates as appropriate. Residents experiencing pain have had pain assessments reviewed with physician	7/11/16

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F 282	Continued From page 41 assessment care plan both dated 7/6/15, indicated the resident was prescribed Coumadin for deep vein thrombosis (DVT) and atrial fibrillation. In addition, R12 was noted to have chronic obstructive pulmonary disease (COPD), delirium and dementia. Staff were to monitor for signs and symptoms of anticoagulant complications and to inform the physician anytime antibiotics are ordered as antibiotics have the potential to affect anticoagulation status. The respiratory care plan indicated R12 received oxygen as ordered (but the signed Physician's Orders dated 5/4/16, did not note any oxygen was ordered), staff were to take the oxygen saturation levels per protocol, monitor for cyanosis, shortness of breath, and change in level of consciousness. The Physician's Order sheet signed by the "nurse reviewer" on 4/30/16, and the physician on 5/4/16, noted R12 was ordered Septra DS (an antibiotic) one tablet by mouth (PO) twice a day for seven days for a urine tract infection. The same order sheet noted R12 to also be on Warfarin 5 milligrams one tablet PO daily. The medication depicted the last INR drawn was on 4/25/16. R12's Summary Behavior Program for 5/1/16, noted R12 had symptoms of delirium. The report directed staff to notice if R12 had "inability to focus on task at hand or conversation being had, illogical flow of ideas, switching from one topic to the next, starring into space, being easily startled, loss of energy, wanting to stay in bed or lay down more often, falling asleep in his chair or during periods of activity, etc." The intervention was staff were to "notify nurse if symptoms of Delirium have been observed, allow resident an	F 282	notification and care Plans updated as appropriate. 3. Licensed Staff have been educated on monitoring and physician notification on medication interactions specifically to Coumadin and antibiotics. Licensed Staff have been educated in regards to the following resident plan of care, medication administration, and pain management. 4. DON/designee will conduct audits on residents receiving Coumadin, Pain management and medication administration audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements. 6. Completion date: July 11th 2016	

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opportunity to rest." The report further noted R12 was hard of hearing and to make sure his hearing was not a factor in symptoms of delirium.

R12's target behavior sheet dated 5/1/16, noted R12 had symptoms of delirium which started on 5/1/16. The facility indicated R12 had one to one staff assist and that was not effective. The Progress Note was void of any documentation that the facility called the physician for the altered mental status in which non-pharmacological interventions was ineffective.

The Occurrence Report dated 5/2/16, noted R12 had a fall in his room. The activity indicated R12 was in the bed prior to the fall. The report depicted, "CNA [certified nursing assistant] found him on floor next to his bed on Left side, bed in low, he was throwing pillows at staff and being very unusual behavior. He had ripped off bandaids on the floor, hip drsg [dressing] almost off, heel drsg in place. Unable to tell if small areas bleeding were new or where he had ripped off bandaids. Area on left outer wrist replaced bandaide and a large drsy [sic] placed on Left side of head." The section for Resident statement noted R12 to be "very confused per usual." The section for executive director and director of nursing to sign noted, "The IDT [interdisciplinary team] Met and reviewed the fall MD [medical doctor] notified and UA [urine analysis] ordered Care Plan Updated." The report reflected R12 sustained an excoriated area on the left side of his head. The Neurological Assessment Flowsheet dated 5/2/16, noted R12 had 16 opportunities for SpO2 levels to be conducted. Of the 16 opportunities only seven readings were recorded either on the neuro sheet or in the Progress Notes. Two of the readings were below

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the recommended levels. The readings were 91% and 94%. The medical record lacked evidence of the residents, breathe sounds, if the lungs were clear, if the resident was short of breathe, if the breathing was labored when R12 had oxygen saturation levels below 95%. The medical record lacked evidence of the physician being notified of the low SpO2 levels to determine if supplemental oxygen was needed for R12. The facility did not comprehensively re-assess R12's change in mental status after R12 was found on the floor and he hit his left side of his head.

Review of R12's Vital Sign - Individual Resident Flowsheet for May of 2016 noted R12 to have oxygen saturation levels (The percentage of oxygen saturation thus calculated is referred to as the percent SpO2) ranging from 95% to 98%. However, on 5/3/16, the O2 level was 91% and on 5/4/16, the level was 92%, which according to the Clinical Use of Pulse Oximetery Pocket Reference Guide dated 2010, "a SpO2 of 92% or less (at sea level) suggests hypoxemia, in a patient with acute respiratory illness (e.g., influenza) or breathing difficulty (e.g., an asthma attack), an SpO2 of 92% or less may indicate a need for oxygen supplementation, and in a patient with stable chronic disease (e.g., COPD), an SpO2 of 92% or less should prompt referral for further investigation of the need for long-term oxygen therapy." There was no oxygen reading documented on the sheet for 5/5/16 and on 5/10/16, the reading was 94%. The medical record lacked evidence of the physician being noted of the low oxygen levels to determine if R12 could have benefited from supplemental oxygen use.

A Progress Note dated 5/7/16, noted R12 to be

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outside with his family. R12 had an emesis and was able to cough and clear his airway on his own power. The temperature was 99.3 and RA O2 sats were 94%. The writer indicated they would monitor R12's condition.

A Progress Note dated 5/9/16, "Also he [R12] is not his normal self today. VS [vital signs] T [temperature] 97.4 P [pulse] 90 R [respirations] 16 B/P [blood pressure] 120/72. Was not able to get O2 [oxygen] reading due to his hands shaking. Resident just does not look like his normal self. Behavior is different." An entry on 5/10/16, noted the nurse practitioner (NP) ordered a STAT [immediately] INR. At 3:15 p.m. a note depicted R12 to be alert per baseline and not in any pain. The last entry on 5/10/16, at 4:30 p.m. noted R12 left for the VA hospital. A Progress Noted 5/11/16, indicated R12 was admitted to the hospital on 5/11/16. Under the note, the entire page and the second page was crossed off which noted "Hospitalized 5/10/16." Again, the facility did not re-assess R12's change in mental status according to the plan of care.

The May 2016 (5/1 through 5/10/16), Treatment Administration record (TAR) sheet noted R12's oxygen levels 11-7 shift was either 96 or 97%, the am shift noted nine levels were documented and of the nine documented three levels were below 95%, and the pm shift noted nine levels were documented and of the nine documented only three levels were above the 95%, with the lowest being 91%. The May 2106 Medication Administration Record (MAR) and TAR did not indicate R12 received any oxygen that month. The medical record lacked evidence of the physician being noted of the low oxygen levels to determine if R12 could have benefited from

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 45 supplemental oxygen use. On 5/27/16, at 10:58 a.m. the caretaker-A and family member (F)-B was interviewed and noted after the resident fell he was not himself. He had nasal drainage which brown in color, repeated different words on different days, such "blue" one day, "Help Me, help me" the next day and also repeated "How are doing" on another day. The caretaker indicated R12's hand was shaking so bad that he could not hold a cigarette. (The facility assessed the resident on 6/26/15, as being able to hold his own cigarette). Both caretaker-A and F-A indicated they did inform the staff however, each time they visited R12 there was a different staff on duty and they did not know if the concerns were followed up on. On 5/29/16, at 10:40 a.m. registered nurse (RN)-A was interviewed and indicated she had worked R12. RN-A indicated she knew of the antibiotic and Coumadin and could give "universal" side effects but could not give specific side effects and what to monitor for when they both used to together. On 5/31/16, 9:22 a.m. the resident's physician was telephoned and left voice message. There was no return call made. On 5/31/16, at 11:20 a.m. the medical director was interviewed. She indicated she had not been made aware of the altered mental changes in R12 after his fall on 5/2/16 and on 5/9/16. She acknowledged she should have been made aware. She reviewed the nurse's notes and indicated she wished there had more documentation to review.	F 282		

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On 5/31/16, at 3:00 p.m. was interviewed and acknowledged she was not specifically made aware nor did she remember if she was informed of R12's change in mental status on 5/2/16 and on 5/9/16. When asked if she had been made aware of the family's and caretaker's concern of R12's shakiness and repetitive word she indicated "No." When asked if she should have been made aware of the R12's condition she stated, "Yes."

The facility's 7/15 Care Plans policy indicated, the staff "Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI [Resident Assessment Information] process, with necessary monitoring and follow up."

R72 had chronic pain without adequate implementation of non-pharmacological interventions.

On 5/24/16, at 8:30 a.m. R72 was observed sitting in his wheelchair in the hallway. He winced, pointed to his shoulder and said he had pain. R72 was observed later the same day at 7:30 a.m. licensed practical nurse (LPN)-B attended to R72 who had been calling out for help. LPN-B asked if in pain and R72 replied, "yes". LPN-B then offered to get something for pain. At 8 a.m. LPN-B returned to assess pain in shoulders and knee. LPN-B asks R72 to rate the pain. R72 could not rate the pain but could say yes to when and where it hurt during the assessment while LPN-B gently moved R72's arms and legs.

On 5/27/16, at 9:41 a.m. R72 was lying in bed. He

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grimaced while the surveyor spoke to the resident. When asked if he was experiencing pain he replied, "Well, yes." When asked where he placed his hand on the right side of his neck and stated, "Right here--in my neck. He then moved his hand up on his head behind his right ear and stated, "And up here. It always hurts." The RN-D was informed of R72's complaints of pain and said he does sometimes complain of pain. R72 was prescribed scheduled Tramadol and "maybe he didn't get it yet or it didn't kick in yet," but said she would check on it. On 5/27/16, at 10:30 a.m. treatment sheets revealed the resident could have been administered Ben Gay topical pain cream but it had not been administered at all during the month.

A pain assessment was completed on, 5/12/16. The assessment lacked input from R72. The resident interview section of the assessment was blank. The instructions were to attempt the interview, but, if the resident was unable to communicate answers, skip to section PAIN section for residents with dementia or non-interviewable. The PAIN section indicated R72 had repeated troubled calling out, loud moaning or groaning and crying, and facial grimace. The assessment lacked a description by the nurse of observed pain location, history, or frequency. The follow up plan was to notify the nurse practitioner. R72 had also experienced a fall on 5/12/16, at 8:00 a.m.

The care plan for R72 indicated a problem with persistent chronic pain. The goal was for R72 to report pain relief within 30-60 minutes of receiving pain medication or treatment; no complaints of pain when questioned; no vocalization of pain; no non-verbal signs of pain; no decline in activity;

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non-pharmacological measures used and no increase in behaviors. Interventions included monitor and record effectiveness of medication, asses for verbal and non-verbal signs and symptoms of pain unrelieved by treatments, and comfort measures of position change and relaxation techniques.

An order was made on 4/7/16, for Tramadol (a medication used to treat pain) changed from 50 milligrams (mg) three time daily PRN (as needed) to a scheduled dose of 25 mg every morning, 50 mg every at bedtime and a dose of 50 mg available twice daily PRN. However, the Medication Administration Record (MAR) showed the PRN Tramadol had been used only once between 4/1/16 to 4/7/16. On 5/13/16, the Tramadol was increased to 50 mg 3 times per day with 50 mg available as needed 2 times per day. However, the PRN Tramadol had not been used at all between 4/8/16 to 5/13/16. The MARs for both April and May lacked documentation of the pain location, rating or effectiveness of the administered PRN Tramadol. The daily shift documentation for pain on the MAR indicated the pain program was effective. BenGay ointment could be used for pain three time per day as needed. The BenGay had not been used during April or May, 2016. The MAR lacked any indication for the use of non-pharmacological interventions.

A registered nurse (RN)-C was interviewed on 5/27/16 8:47 a.m. She explained pain assessments were completed on admission, quarterly and with a change in condition. RN- C explained the nurse practitioner or physician were to be notified if a resident had an increase in pain so they could evaluate.

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During interview on 5/27/16 10:14 a.m. NA-R said R72's shoulders hurt and she tried to give a massage, but it hurt just to touch so she stopped the massage and notified the nurse of the pain. NA-R said she could use ice on R72's knee.

The policy for pain management, dated July, 2015, indicated a full assessment included pain origin, location, frequency, type, severity, alleviating factors, exacerbating factors, current treatment and response to treatment. Verbal and non verbal expressions of pain were to be included in the assessment. The policy indicated resident self-reporting as the most reliable indicator of pain. Residents with cognitive impairment would be assessed based on objective

R8 was observed while seated in a wheelchair in her room on 5/23/16, at 2:22 p.m. She had labored breathing and was moaning. She had a pained facial grimace. When asked if she was in pain she nodded and moved her hand up and down her left thigh and hip area. The therapeutic recreation director entered the room and explained that she had been in an activity but was brought back to her room because she was seemingly in pain. He stated staff was planning to assiste her to lie down and give her pain medication.

R8's diagnosis include: history of breast cancer, diabetic neuropathy, degenerative joint disease and temporomandibular joint dysfunction.

The current physician orders for R8 include the following medications: Hydromorphone HCL1 milligram (mg) every (q) morning for pain,

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F 282	Continued From page 50 Fentanyl C2 75 micrograms (mcg)/hour (hr) patch TD72 apply 1 and change q 72 hours for pain (medication has boxed warning), A review of the May 2016 medication administration record (MAR) confirmed the Fentanyl patch was not administered on two consecutive occasions, 5/19/16 and 5/22/16. The MAR also showed Hydromorphone HCL1 mg prn was administered one time during the month, on 5/24/16. Acetaminophen prn was not given. . A review of R8's current care plan for pain, dated 9/10/15, identifies her as having persistent (chronic) pain with potential for alteration in comfort secondary to abdominal pain, right and left side pain in upper and lower extremities, left leg pain, OA, TMJ, and history of breast cancer and directs staff to administer pain medication as ordered (updated 8/16), monitor and record effectiveness and side effects of (pain) medication prn, assess for verbal and not-verbal signs and symptoms of distress or pain unrelieved by ordered treatments/medications., and observe during rest and movement for pain. An interview on 5/26/16 at 7:44 a.m., an interim registered nurse, (RN)-E stated that on Monday after staff informed her of the situation regarding R8's increased pain, she looked into the incident and found R8 had not received 2 consecutive Fentanyl patch applications on 5/19/16 and 5/22/16 during the evening shifts. RN-E stated an incident report was filled out and the doctor was called. An interview with the director of nursing on 5/31/16, at 10:03 a.m. revealed she expects staff to go through the MARs thoroughly and give all medications as ordered and as per the resident's	F 282		

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F 282	Continued From page 51 current care plan directs.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure timely medical care was provided for a resident who experienced a fall with subsequent cognitive and behavioral changes, and significant physical symptoms for 1 of 2 residents (R12) whose closed records were reviewed. This resulted in actual harm for R12 who was hospitalized following a fall and died 5/15/16. In addition, the faclity failed to ensure edema was appropriately assessed and treated for 1 of 1 residents (R31) reviewed with bilateral edema and that pain was appropriately managed for 3 of 3 residents (R72, R8, R100) reviewed with pain. Findings include: R12 had a fall in his room as noted by the Occurrence Report dated 5/2/16. The activity section indicated R12 was in the bed prior to the fall. The report depicted, "CNA [certified nursing assistant] found him on floor next to his bed on Left side, bed in low, he was throwing pillows at	F 309	1. R12. R100, and R31 no longer reside at the facility. R72 and R8 have been comprehensively assessed for pain and physician has been notified with Care plan updates as appropriate. 2. Residents who reside at PHR have the potential to be affected by this practice. Residents identified with a change in condition in the past 30 days have been assessed and plans of care have been reviewed and updated. Physicians will be notified as needed and plans of care will be upcated to reflect any changes. Resdints that reside at PHR that experience pain have the potential to be affected by this practice. Residents experiencing pain have had pain assessments reviewed with physician notification and care Plans updated as appropriate. 3. Licensed nurses have been re-educated related to the facilities policies and procedures on change of	7/11/16

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F 309	Continued From page 52 staff and being very unusual behavior. He had ripped off bandaids on the floor, hip drsg [dressing] almost off, heel drsg in place. Unable to tell if small areas bleeding were new or where he had ripped off bandaids. Area on left outer wrist replaced bandaide and a large drsy [sic] placed on Left side of head." The section for Resident statement noted R12 to be "very confused per usual." The section for executive director and director of nursing to sign noted, "The IDT [interdisciplinary team] Met and reviewed the fall MD [medical doctor] notified and UA [urine analysis] ordered Care Plan Updated." The report reflected R12 sustained an excoriated area on the left side of his head. The Neurological Assessment Flowsheet dated 5/2/16, noted R12 had 16 opportunities for SpO2 levels to be conducted. Of the 16 opportunities only seven readings were recorded either on the neuro sheet or in the Progress Notes. Two of the readings were below the recommended levels. The readings were 91% and 94%. The medical record lacked evidence of the residents, breathe sounds, if the lungs were clear, if the resident was short of breathe, if the breathing was labored when R12 had oxygen saturation levels below 95%. The medical record lacked evidence of the physician being notified of the low SpO2 levels to determine if supplemental oxygen was needed for R12. The facility did not comprehensively re-assess R12's change in mental status after R12 was found on the floor and he hit his left side of his head. The occurrence log dated 5/2/16, indicated R12 had a fall at 5:05 a.m. The report noted R12 "fell to the ground." The untitled sheet which contained a column for Office of Health Complaints (OHFC) project number sheet was reviewed for entries on 5/2/16, and R12's fall was	F 309	condition. Communication from shift to shift on resident status and change will occur over the 24 hour report. The facilities acute change in resident status reports will be pulled by DON/designee M-F and residents that are triggering for a change will have an assessment completed, Care Plan update, MD and family notification as needed. Residents identified with a change in condition will be reviewed through the facilities clinical meeting process for follow up. Licensed staff have been educated in regards to following residents Plan of Care, medication administration and pain management. 4. DON/designee will review residents with a change in their health status and complete audits to assure notification of emergency contacts and MD occur with changes in condition. Audits will be completed M-F x 4 weeks, then 3 x weekly x 3 months. DON/designee will conduct audits on Care Plans for pain management and medication administration on residents 3 x per week x 4 weeks and then 3 x per month x 3 months. 5. DON/designee will forward all reviews of change in condition program and Pain management audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	

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not called in to OHFC. The Common Entry Point (CEP) Reporting Log was reviewed for the date of 5/2/16, and no report was made to CEP on 5/2/16, regarding R12's fall.

Further review of the medical record indicated the facility did not comprehensively assess R12's altered mental status changes and the facility failed to identify the concurrent use of antibiotics, anticoagulants. The medical record reflected the following:

R12's care plan for mood and behavior symptoms dated 9/11/15, respiratory care plan, and anticoagulant assessment care plan both dated 7/6/15, indicated the resident use Coumadin (blood thinner) for treatment of deep vein thrombosis (DVT) and atrial fibrillation. In addition, R12's care plan noted the resident had chronic obstructive pulmonary disease (COPD), delirium and dementia. Interventions included for staff to monitor for signs and symptoms of anticoagulant complications and to inform the physician anytime antibiotics are ordered as antibiotics have the potential to affect anticoagulation status. The respiratory care plan indicated R12 received oxygen as ordered (but the signed Physician's Orders dated 5/4/16, did not note any oxygen was ordered), staff were to take the oxygen saturation levels per protocol, monitor for cyanosis, shortness of breathe, and change in level of consciousness.

The record indicated R12 had been admitted to the Veteran's Administration (VA) hospital from the nursing home on 1/24/16. According to the History and Physical (H&P) from the VA hospital, R12 had been initially hypoxic with an oxygen saturation level of 85% using room air which had

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improved with application of three liters of oxygen. The H&P also indicated R12 had been admitted following mental status changes, fever, desaturation, and decreased urine output and indicated, "Nurse from NH [nursing home] did mention that this is commonly his issue when he becomes sick from any source." The H&P indicated a possible disposition of sepsis.

R12's a Physician's order documented on a Laboratory Results worksheet dated 3/7/16 noted: "*Continues on 5 mg (milligrams)[of coumadin] daily. *Currently taking levofloxacin 750 mg daily x 7 days (started 3/3/16). Hold re., [check mark] Thursday. The record further indicated R12 had utilized Coumadin for treatment of deep vein thrombosis (DVT) and the therapeutic level for INR (international normalized ratio of blood clotting tendency) was to be between 2.0 to 3.0. A Laboratory Results sheet printed on 3/7/16, at 8:03 a.m. revealed a high INR at 3.48 (the laboratory's reference range was identified as 2.40). Further review of the resident's Laboratory Results indicated an INR of 2.07 on 2/24/16, and 2.4 on 3/2/16. On 3/15/16, the INR result was recorded as 2.92. The resident's coumadin (warfarin generic equivalent-blood thinner) had been decreased to 4 mg and a recheck of the INR was scheduled for the following Thursday.

On 4/21/16, the Quarterly Nursing Data Collection and Assessment sheet identified R12 as being alert, speech was clear but sometimes slurred, had no difficulty breathing or shortness of breath with exertion, sitting, at rest or lying flat. On 4/29/16, R12's Compressed Behavior Report noted R12 had demonstrated symptoms of behaviors and had wandered on 5/1/16.

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On 4/29/16, an antibiotic was again ordered for R12 however, the notes failed to reflect whether the physician had been reminded the resident was still receiving Coumadin. In addition, subsequent notes dated 4/30/16 and 5/1/16, also failed to reflect physician notification of this.

On 4/30/16, a Progress Note documented by a nurse, indicated R12 had even and non-labored respirations, no shortness of breath or congestion.

The Physician's Order sheet signed by the "nurse reviewer" on 4/30/16, and the physician on 5/4/16, noted R12 had been prescribed Septra DS (an antibiotic) one tablet by mouth (PO) twice a day for seven days to treat a urinary tract infection (UTI). The order sheet also indicated R12 was taking warfarin 5 mg one tablet PO daily. The record indicated the last INR had been drawn on 4/25/16, and had measured 2.62 (per the Laboratory Sheet, the parameters for DVT was to keep the INR between 2.0 and 3.0). In addition, physician orders directed the staff to obtain oxygen saturation levels every shift (no parameters were identified for when staff were to notifiy the physician). R12 had no supplemental oxygen ordered.

The April 2016 Treatment Administration Record (TAR) noted R12's SpO2 (oxygen saturation) levels to be from 91% to 98%. The 11:00 p.m.-7 a.m. shift (labeled as C) indicated R12's SpO2s as 95 to 98%. The day shift (labeled as A) identified the SpO2 as 94 to 98%, and the evening shift (labeled as B) indicated R12's SpO2 to be below 95% 19 times out of 28 days. The April Medication Administration Record (MAR)

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and TAR did not indicate R12 received oxygen that month. The medical record lacked evidence of the residents, breathe sounds, if the lungs were clear, if the resident was short of breathe, if the breathing was labored when R12 had oxygen saturation levels below 95%.

R12's target behavior sheet dated 5/1/16, noted R12 had symptoms of delirium which started on 5/1/16. The facility indicated R12 had one to one staff assist and that was not effective. The Progress Note was void of any documentation that the facility called the physician for the altered mental status in which non-pharmacological interventions was ineffective.

R12's Summary Behavior Program for 5/1/16, noted R12 had symptoms of delirium. The report directed staff to notice if R12 had "inability to focus on task at hand or conversation being had, illogical flow of ideas, switching from one topic to the next, starring into space, being easily startled, loss of energy, wanting to stay in bed or lay down more often, falling asleep in his chair or during periods of activity, etc." The intervention was staff were to "notify nurse if symptoms of Delirium have been observed, allow resident an opportunity to rest." The report further noted R12 was hard of hearing and to make sure his hearing was not a factor in symptoms of delirium.

There were no comments about R12 being on both Septra and Coumadin. On a Laboratory Results sheet printed on 5/2/16, at 2:08 p.m. an INR was noted to be 5.73 (HH). On 5/2/16, the nurses' notes reflected, "The NP called back. The only order given was for a UA/UC and monitor resident. He is on neuros and vital signs. He has still not been coherent and himself. Dressing

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changes done. Lab called also to report a critical INR of 5.73. Call was made to MD. Left a message." The note was unclear if the NP was fully made aware of the resident's change in mental status.

The VOHRA (name of company) wound MD saw R12 in 5/4/16, and noted R12 had sustained a left head wound which measured 0.6 by 0.9 centimeters (CM) and there was light sero-sanguinous drainage. The intervention was to keep a clear occlusive dressing in place.

A letter to the facility dated 5/6/16, indicated the VA hospital had placed the facility on hold for their for new VA contracts for over six months. "Those concerns included; turn-over in key leadership staff; hiring, training, retention of quality nursing assistants and nurses; infection control; and wound care staff. These concerns remain and are even heightened at this time with the recent departure of the administrator, DON [director of nursing], social work and business office manager." The letter further remarked, the VA staff have communicated concerns during their recent on-site visit which included wound care, cleanliness of the rooms, and "INR monitoring - concern was based on chart findings in what should be standard care following those findings."

A Progress Note dated 5/7/16, noted R12 to be outside with his family. R12 had an emesis and was able to cough and clear his airway on his own power. The writer questioned aspiration and noted R12 was not coughing. It was unclear if lung sounds were performed to determine if the lungs were free from from wheezing, crackles, diminished breath sounds, etc. The temperature was 99.3 and RA O2 sats were 94%. The writer

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indicated they would monitor R12's condition.

A progress note on 5/8/16, noted R12 to be free of cough and emesis. It was unclear if lung sounds were performed to determine if the lungs were free from from wheezing, crackles, diminished breath sounds, etc.

A Progress Note dated 5/9/16, at 8:15 a.m. indicated the facility called the MD about the INR and "Also he [R12] is not his normal self today. VS [vital signs] T [temperature] 97.4 P [pulse] 90 R [respirations] 16 B/P [blood pressure] 120/72. Was not able to get O2 [oxygen] reading due to his hands shaking. Resident just does not look like his normal self. Behavior is different." An entry on 5/9/16, noted the nurse practitioner (NP) ordered a STAT [immediately] INR. On 5/10/16, at 3:15 p.m. a note depicted R12 to be alert per baseline and not in any pain. The last entry on 5/10/16, at 4:30 p.m. noted R12 left for the VA hospital. A Progress Note dated 5/11/16, indicated R12 was admitted to the hospital on 5/11/16. Under the note, the entire page and the second page was crossed off which noted "Hospitalized 5/10/16." Again, the facility did not comprehensively re-assess R12's change in mental status.

A resident concern form dated 5/9/16, was noted for R12. The nature of the concern was R12's condition of the wound and cleanliness of his room. Staff indicated they reviewed the wound assessment and Physician Notes. The form went to indicated R12 had a recent change in treatment and that the wound had shown improvement as a result of a turning and repositioning schedule being implemented. R12 had been educated to refrain from lying on the

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wound area to enable healing. The note further remarked that R12 was hospitalized prior to the completion of the concern form. However, the form was void of any follow up for the monitoring of the INR monitoring.

On 5/10/16, the VOHRA MD saw R12 and noted the wound measured 0.6 by 0.5 cm. The wound still light ser- sanguineous drainage. The intervention was to apply skin prep (a liquid film-forming dressing that, upon application to intact film to help reduce friction) daily.

Review of R12's Vital Sign - Individual Resident Flowsheet for May of 2016 noted R12 to have oxygen saturation levels ranging from 95% to 98%. However, on 5/3/16, the O2 level was 91% and on 5/4/16, the level was 92%, which according to the Clinical Use of Pulse Oximetery Pocket Reference Guide dated 2010, "a SpO2 of 92% or less (at sea level) suggests hypoxemia, in a patient with acute respiratory illness (e.g., influenza) or breathing difficulty (e.g., an asthma attack), an SpO2 of 92% or less may indicate a need for oxygen supplementation, and in a patient with stable chronic disease (e.g., COPD), an SpO2 of 92% or less should prompt referral for further investigation of the need for long-term oxygen therapy." There was no oxygen reading documented on the sheet for 5/5/16 and on 5/10/16, the reading was 94%. The medical record lacked evidence of the physician being noted of the low oxygen levels to determine if R12 could have benefited from supplemental oxygen use.

The VA hospital admission H&P dated 5/10/16, indicated R12 was admitted to the VA hospital. The VA H&P indicated R12 had several

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admissions to the hospital in past per the family and per the VA computerized patient reporting system for "altered mental status in the past year." The VA lab report imbedded in the H&P noted R12 had a low hemoglobin (9.6 - The normal HGB level for males is 14 to 18 grams per deciliter. HGB c) and a low red blood cell count (3.48 - Male: 4.7 to 6.1 million cells per microliter (cells/mcL). RBCs contain hemoglobin, which carries oxygen to your body's tissues).

On 5/12/16, R12's VA medical record noted the following: On 5/1/16, Warfarin dose was 5 mg and R12 was stared on Bactrim on 4/30/16, p.m. On 5/2/16, the INR was 5.73 and the warfarin was held. On 5/3/16, the INR was 2.28 and R12 was given 2.5 mg of warfarin, on 5/4/16, R12 was given 2.5 mg of warfarin. On 5/5/16, the INR was 4.32 and the warfarin was held on that date and the date of 5/6/16. On 5/7/16, the INR was 2.46 and the warfarin was held "*RN states unable to contact on-call MD on Sat [Saturday] Last days of Bactrim therapy." On 5/8/16, no INR was drawn, "*RN states unable to contact on-call MD on Sun [Sunday]." The NH Progress Notes noted the INR was drawn lat and the results were 1.80. The note further commented they were awaiting the MD's return call. On 5/9/16, the INR was 1.51 and warfarin was ordered at 3 mg. On 5/10/16, INR was 1.35 "** 4.5 mg ordered for 5 pm nut not given at NH; admit to Minneapolis VAMC; NH [nursing home] recheck INR on 5/13." The VA assessment plan noted, "INR subtherapeutic likely related to several held doses at NH prior to admit related to subtherapeutic INR and inability to obtain order from on call NH MD. Subtherapeutic INR at NH is likely related to drug interaction with Bactrim therapy started on 4/30/16 -- which can lead to significant increases

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in the INR. Bactrim course was completed on 5/7/16. Pt's warfarin dosing history from the month of April is not available at this time so assess warfarin regimen prior to Bactrim start."

A Progress Note dated 5/17/16, noted on 5/10/16 [implied late entry although not noted as such], R12 was seen by the wound doctor and both wounds have shown improvement. The note went onto state that the VA nurse requested R12 be sent to the VA hospital for wound evaluation on 5/11/16. The wound vac was removed and a wet to dry dressing was applied to the wound for transport. (The note date of 5/11/16, contraindicated the Physician Order dated 5/10/16, and the Progress Note of 5/10/16, which indicated the resident was sent to the VA hospital for an evaluation). According to the facility's documentation it could not be determined when R12 was sent to the hospital.

The May 2016 (5/1 through 5/10/16), TAR sheet noted R12's oxygen levels 11-7 shift was either 96 or 97%, the am shift noted nine levels were documented and of the nine documented three levels were below 95%, and the pm shift noted nine levels were documented and of the nine documented only three levels were above the 95%, with the lowest being 91%. The May 2106 MAR and TAR did not indicate R12 received any oxygen that month. The medical record lacked evidence of the physician being noted of the low oxygen levels to determine if R12 could have benefited from supplemental oxygen use.

On 5/27/16, at 10:58 a.m. caretaker-A and family member (F)-B was interviewed and noted after the resident fell he was not himself. He had nasal drainage which brown in color, repeated different

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words on different days, such "blue" one day, "Help Me, help me" the next day and also repeated "How are doing" on another day. The caretaker indicated R12's hand was shaking so bad that he could not hold a cigarette. (The facility assessed the resident on 6/26/15, as being able to hold his own cigarette). Both caretaker-A and F-A indicated they did inform the staff however, each time they visited R12 there was a different staff on duty and they did know if the concerns were followed up on.

On 5/29/16, at 10:05 a.m. a licensed practical nurse (LPN)-A was interviewed regarding education of antibiotic and Coumadin use. She indicated there had been no training since she had been here hired as of 4/20/16.

On 5/29/16, at 10:40 a.m. a registered nurse (RN)-A was interviewed and indicated she had worked with R12. RN-A indicated she knew of the antibiotic and Coumadin use and could give "universal" side effects but could not give specific side effects and what to monitor for when they both used to together.

On 5/29/16, at 2:43 p.m. RN-F, field director of education and training verbally stated, "No do not believe it has been done. It has not been assigned by Relias." It was verified by looking at a RN educational file who had been here since 1/26/16, and there was no education on Coumadin or antibiotic use. RN-F looked at the modules educational library and there was one course on dangerous medication and insulin and nothing on antibiotics. RN-F came here in March. No education modules on Coumadin and antibiotics. "I know what she [the surveyor as told to the IDON] is talking about as I have been on

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Coumadin and you do not mix certain antibiotics."

On 5/29/16, at 2:43 p.m. RN-G, field director of education and training noted there was no training in the paper educational files. The interim director of nursing (IDON) checked as well no training in the paper files.

On 5/29/16, at 2:50 p.m. the IDON called the old administrator, regarding the VA letter for our response. 2:52 p.m. Any education on training for antibiotics and Coumadin together and the answer was she does not recall any education that was done. IDON checked all three manila folders and a stack of rubber-banded papers. No training could be located for R12.

On 5/29/16, at 2:55 p.m. per RN-E, unit manager, confirmed there had not been any education with staff done for Coumadin and antibiotics combined use.

On 5/31/16, at 11:20 a.m. the medical director was interviewed. She indicated she had not been made aware of the altered mental status in R12 after his fall on 5/2/16 and on 5/9/16. She acknowledged she should have been made aware. She reviewed the nurse's notes and indicated she wished there had more documentation to review.

On 5/31/16, at 3:00 p.m. NP-A was interviewed and acknowledged she had ordered a urine culture on 5/2/16, but was not specifically made aware nor did she remember if she was informed of R12's change in mental status on 5/2/16, and also on 5/9/16. When asked if she had been made aware of the family's and caretaker's concern of R12's shakiness and repetitive words

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F 309	Continued From page 64 she indicated "No." When asked if she should have been made aware of the R12's condition she stated, "Yes." The IDON was interviewed on 6/1/16, at 2:49 p.m. she indicated the facility was aware of the R12's altered mental status on 5/1/16, and that the nursing staff had called the physician on 5/2/16, and an UA was ordered. On 6/1/16, at 3:45 p.m. both licensed practical nurse-B and nursing assistant-B were interviewed. They both knew who R12 was but could not describe what cares had been provided to R12. The facility utilized a 7/15, Signs and Symptoms A's when to notify the physician tool. The section for Altered Mental Status directed the staff to call immediately for an "abrupt significant change in cognitive function from usual with or without altered level of consciousness" or for "non-immediate when the symptoms were identified as persistent change from usual cognitive function with no other criteria met for immediate notification." Drugs.com noted the interaction between Coumadin and Septra to be one a major interaction. "Using warfarin together with sulfamethoxazole may increase the risk of bleeding, especially if you are elderly or have kidney or liver impairment. You may need more frequent monitoring of your prothrombin time or INR by your doctor to safely use both medications. Call your doctor promptly if you experience any unusual bleeding or bruising, swelling, vomiting, blood in your urine or stools, headache, dizziness, or weakness during	F 309		

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treatment with these medications."

The facility's 7/15, Notification of Resident Change in Condition policy indicated facility clinicians will immediately inform the physician and resident's legal representative when there is a significant change in physical, mental, or psychosocial status. According to the policy, documentation was to be completed in the nursing progress notes the time notification was given. A policy for monitoring oxygen saturations levels was requested and the facility indicated they have no policy.

The facility did not re-assess R12's altered mental status after R2 fell on 5/2/16, and hit his head, had behavioral changes, had displayed altered mental status when the resident was noted to be on Coumadin and Septra simultaneously, the facility did not act upon the family and caretaker information for the change in mental status of R12's shakiness and of the repetitive words after R12 fell, and the facility did not re-assess R12 on 5/9/16, when he again had altered behavioral changes. R12 was not re-assessed after his oxygen saturations level fell below 95%. R12 was harmed as R12's physician was not informed of the altered mental status changes.

R31 had a significant event with sever edema (fluid build up) of her legs leading to fluid weeping from her legs. Medication orders that may have contributed to the edema were not correctly documented for proper physician notification.

On 05/24/16 10:29 a.m. Family Member (FM)-C was interviewed and explained the course of events leading up to the edema. FM-C explained,

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at the time of admission, 4/21/16, R31 was walking, eating, and alert. FM-C believed R31 was to have her legs elevated at all times due to the edema. However, when FM-C came daily to visit she would find R31 with her legs down. FM-C stated, it was a struggle at the facility to get a recliner that worked properly to keep the legs up.

On 5/20/16, FM-A came for her daily visit and found R31 sitting in the recliner with legs down. R31's legs were very swollen, her pant's legs and socks were wet and there was a puddle of fluid on the floor by her feet. R31 was also confused. FM-C become upset and quickly notified the staff of the situation. FM-C requested information to file a formal complaint regarding the facilities lack of attention to keeping R31's feet elevated.

On 5/25/16, at 7:18 a.m., Nursing Assistant (NA)-C was observed assisting R31. NA-C asked R31 if she would like to put her feet up. R31 initially declined, but, then agreed to put feet up with encouragement from NA-C.

The Comprehensive Admission Data collection and Assessment, dated 4/21/16, indicated no edema present. A nursing noted, dated 4/24/16, indicated R31 had 2+ pitting edema (a situation in which the swelling is severe enough to leave a dent in the skin for 10 to 15 seconds when pressed with the finger). On 4/25/16, a nursing note again identified the 2+ pitting edema. The medical administration record (MAR) for April indicated 2+ edema from 4/24/16 through 4/30/16. The initial admit progress note, 4/27/16, completed by R31's medical doctor (MD) indicated no edema. The progress note included 2 diagnoses that could contribute to edema,

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chronic kidney disease, stage 3 and congestive heart failure. The plan was to continue to monitor. The admission Minimum Data Set (MDS) assessment dated 4/28/16, and the 14 day MDS dated 5/8/16, did not identify edema as an active diagnosis. A care conference was held on 5/17/16. Social services documentation from the care conference meeting indicated nursing was to followu up on bi-lateral (both sides) lower edema

On 5/2/16, the edema was noted as bilateral edema of all four extremities and R31 had wheezing. The level of edema was not identified. The primary medical doctor (MD) was notified by phone. The physician's telephone orders, dated 5/2/16, indicated a diagnosis of wheezing with orders for in house psychology, and a medication to help with breathing. The edema was not addressed.

On 5/3/16 a telephone order was completed for 1 gram of sodium to be given daily for seven days and a fluid restriction for seven days, for a diagnosis of low sodium. On 5/12/16, Nurse Practitioner (NP)-L's note indicated 1+ edema. On 5/13/16, a nursing note indicated 1+ edema of the lower extremities and R31 was encouraged to keep feet elevated. On 5/16/16 a nursing note indicated R31 had a weight gain of over 2 pounds in 2 days with "ongoing 2+ pitting edema" and NP-L was notified. The MAR for May, 2016 had an order for sodium 1 gram daily for 14 days dated 5/10/16. There was no corresponding signed physician's telephone order in the record.

A telephone order, dated 5/16/16, indicated a diagnosis of anxiety with medication ordered to help relieve anxiety. On 5/19/16, a nursing note indicated 2+ bilateral edema with encouragement

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to keep legs elevated. A nursing note on 5/20/16, indicated, "writer called physician" but did not indicate the purpose for the call. The nursing notes lacked any description of the events on 5/20/16, as reported by FM-C. The nursing notes lacked description of R31 having fluid weeping from her legs, or FM-C reporting the incident to staff. The record also lacked any on going tracking of the level of edema and/or fluid weeping from the legs after 5/20/16.

NP-L's visit note of 5/20/16 indicated R31 was seen for a change of condition. R31 was in reclining chair alert only to stimuli which was a significant change to previous level of consciousness. R31's legs were swollen, but not pitting, weeping moderate amounts of fluid. NP-L did discontinue the sodium pill, wrote orders to keep resident in bed with lower extremities elevated, and increased a medication to help relieve fluid build up. The note indicated FM-C reported R31 said she was ready to die. On 5/26/16 at 2:10 p.m., Registered Nurse (RN)-C said, "If her legs are down they will swell up."

NP-L was interviewed on 5/31/16, at 12:30 p.m. and explained the events of 5/20/15. NP-L stated FM-C found R31 with swollen legs and fluid weeping from the legs. NP-L made a visit that day and found the resident to have a significant change in condition. Medication was increased to remove excess fluid with good results and R31 had since been more alert. NP-L stated every time she saw R31 there was edema and would be surprised if R31 had not had edema when admitted. When asked about administering sodium to someone with edema, NP-L verified it could worsen the edema, but was more concerned with the low sodium levels than

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increased edema. NP-L verified she had not notified the MD about the weeping legs and had discontinued the sodium.

On 6/1/16, at 10:00 a.m., the primary MD was interviewed. She verified the sodium could have contributed to the edema and said, "It now makes more sense now about her drastic change in her legs with the extra sodium." The MD stated R31's sodium levels could have been low due to the diagnosis of congestive heart failure with edema.

R72 had chronic pain without adequate assessment, documentation, and implementation of non-pharmacological interventions.

On 5/24/16, at 7:30 a.m. R72 was observed calling out for help. LPN-B asked if R72 was in pain and he replied, "Yes". LPN-B then offered to get something for pain. At 8:00 a.m. LPN-B returned to assess pain in shoulders and knee. LPN-B asked R72 to rate the pain. R72 could not rate the pain but could say yes to when and where it hurt during the assessment while LPN-B gently moved R72's arms and legs. At 8:36 a.m. R72 was observed sitting in his wheelchair in the hall way. He winced, pointed to his shoulder and stated he had pain.

On 5/27/16, at 9:41 a.m. R72 was lying in bed. He grimaced while the surveyor spoke to the resident. When asked if he was experiencing pain he replied, "Well, yes." When asked where the pain was, R72 placed his hand on the right side of his neck and stated, "Right here--in my neck. He then moved his hand up on his head behind his right ear and stated, "And up here. It always hurts." RN-D was informed of R72's complaints of

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pain and RN-D stated he did sometimes complain of pain. R72 was prescribed scheduled Tramadol and "maybe he didn't get it yet or it didn't kick in yet," but said she would check on it. On 5/27/16, at 10:30 a.m. treatment sheets revealed the resident could have been administered Ben Gay topical pain cream but it had not been administered during the month of 5/16.

A pain assessment was completed on, 5/12/16. The assessment lacked input from R72. The resident interview section of the assessment was blank. The instructions were to attempt the interview, but if the resident was unable to communicate answers, skip to the PAIN section for residents with dementia or non-interviewable residents. The PAIN section indicated R72 had repeated calling out, loud moaning or groaning and crying, and facial grimacing. The assessment lacked a description by the nurse of observed pain location, history, or frequency. The follow up plan was to notify the nurse practitioner.

The care plan for R72 indicated a problem with persistent chronic pain. The goal was for R72 to report pain relief within 30-60 minutes of receiving pain medication or treatment; no complaints of pain when questioned; no vocalization of pain; no non-verbal signs of pain; no decline in activity; non-pharmacological measures used and no increase in behaviors. Interventions included monitor and record effectiveness of medication, assess for verbal and non-verbal signs and symptoms of pain unrelieved by treatments, and comfort measures of position change and relaxation techniques.

An order dated 4/7/16, for Tramadol (a pain medication) changed from 50 milligrams (mg)

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F 309	Continued From page 71 three time daily as needed (PRN) to a scheduled dose of 25 mg every morning, 50 mg at bedtime and a dose of 50 mg available twice daily PRN. However, the Medication Administration Record (MAR) showed the PRN Tramadol had been used only once between 4/1/16 to 4/7/16. On 5/13/16, the Tramadol was increased to 50 mg 3 times per day with 50 mg available as needed 2 times per day. However, the PRN Tramadol had not been given to R72 from 4/8/16 to 5/13/16. The MARs for both4/16 and 5/16 lacked documentation of the pain location, rating or effectiveness of the administered PRN Tramadol. The daily shift documentation for pain on the MAR indicated the pain program was effective. BenGay ointment could be provided for pain relief three times per day PRN. The BenGay had not been used 4/16or 5/16. The MAR lacked any identification of the implementation of non-pharmacological interventions. R72's primary physician was interviewed on 5/31/16, at 11:10 a.m. She explained sometimes there would be an increase to pain medication even though the PRN medications or non-pharmacological interventions had not been tried first. She explained this may happen when the resident does not have the cognitive skill to say he has pain or to ask for the medication. She verified, to her recollection, nursing had not called about pain. The medication was increased based on physical exam. Also, behaviors can be a manifestation of pain, and R72 did have some disruptive behaviors. On 4/26/16, an order was made by Nurse Practitioner (NP)-B to document daily on R72's behaviors. The order was to document how frequent, time of occurrence, document on MAR	F 309		

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and in progress notes, and update NP-B in one week. Review of the 4/16 and 5/16 MAR's revealed no daily documentation of behaviors. Daily progress notes were completed from 4/27/16 to 5/1/16, but lacked notes for 5/2/16 and 5/3/16.

NP-B was interviewed on 5/27/16, 9:47 a.m. NP-B stated R72 had degenerative joint disease (arthritis) with pain in the knee, and frequent falls. NP-B explained she made the determination to change R72's pain medicaiton based on nursing providing information of R72 having more pain. NP-B also assessed R72 by moving his extremities to see when he grimaced, and determined he had pain in his knee. NP-B verified she was not aware of PRN use as "that's a nursing thing". NP-B was also not aware of specific non pharmacological interventions as that would also "be a nursing thing." NP-B suggested nursing could offer ice or re- positioning.

Registered nurse (RN)-C was interviewed on 5/27/16 at 8:47 a.m. She explained pain assessments were completed on admission, quarterly and with a change in condition. RN- C explained the nurse practitioner or physician was to be notified if a resident had an increase in pain so they could evaluate.

During interview on 5/27/16 10:14 a.m., nursing assistant (NA)-R said R72's shoulders hurt and she tried to give a massage, but it hurt just to touch so she stopped the massage and notified the nurse. NA-R said she could use ice on R72's knee.

The policy for pain management, dated July, 2015, indicated a full assessment included pain

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F 309	Continued From page 73 origin, location, frequency, type, severity, alleviating factors, exacerbating factors, current treatment and response to treatment. Verbal and non verbal expressions of pain were to be included in the assessment. The policy indicated resident self-reporting as the most reliable indicator of pain. Residents with cognitive impairment would be assessed based on objective clinical assessments, use of a "proxy" pain reporting and behavioral characteristics. The interdisciplinary team would work with the resident and significant others to establish a care plan that would address the individual's goals for comfort and function. The policy also indicated when medication is indicated, the goal will be to provide satisfactory pain relief by using the lowest possible dose of a medication. R8 was observed while seated in a wheelchair in her room on 5/23/16, at 2:22 p.m. She had labored breathing and was moaning. She had a pained facial grimace. When asked if she was in pain she nodded and moved her hand up and down her left thigh and hip area. The therapeutic recreation director entered the room and explained that she had been in an activity but was brought back to her room because she was seemingly in pain. He stated staff was planning to assist her to lie down and give her pain medication. R8's diagnoses included a history of breast cancer, diabetic neuropathy, degenerative joint disease and temporomandibular joint dysfunction (TMJ). The current physician orders for R8 included the following medications: Hydromorphone HCL1 milligram (mg) every (q) morning for pain, Fentanyl C2 75 micrograms (mcg)/hour (hr) patch	F 309		

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TD72 apply 1 and change q 72 hours for pain (medication has boxed warning), Mypap Arthritis Pain 650 mg tablet extended relief one tablet three times daily (TID), Gabapentin 1000 mg TID for neuropathy (nerve pain), Hydromorphone HCL1 milligram (mg) every (q) evening as needed for pain (prn), and acetaminophen (Tylenol) 650 mg q 4 hrs prn.

A review of the 5/16 medication administration record (MAR) confirmed the Fentanyl patch was not administered on two consecutive occasions: 5/19/16 and 5/22/16. The MAR also showed Hydromorphone HCL1 mg PRN was administered one time during the month, on 5/24/16. The PRN acetaminophen was not given.

On 5/25/16, at 2:00 p.m. R8 was observed sitting in her room watching television. When asked if she had pain she shook her head and said no. When asked if she was feeling better she nodded her head and said yes.

A review of R8's current care plan for pain, dated 9/10/15, identified her as having persistent (chronic) pain with potential for alteration in comfort secondary to abdominal pain, right and left side pain in upper and lower extremities, left leg pain, arthritis, TMJ, and history of breast cancer. The care plan directed staff to administer pain medication as ordered, monitor and record effectiveness and side effects of (pain) medication PRN, assess for verbal and not-verbal signs and symptoms of distress or pain unrelieved by ordered treatments/medications, and observe during rest and movement for pain.

The Mood and Behavior care plan, revised 5/13/16, stated R8 nods head up and down for

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"yes" and side-to-side for "no" questions.

The Pain Data Collection Assessment dated 5/15/16, although incomplete, indicated Painad (an assessment for those unable to communicate pain level effectively) score of 3/10. Another pain assessment completed on 5/24/16 identified a Painad score of 1/10 and identified R8 had diagnoses contributing to pain: arthritis and leg cramps and received "Duragesic 75 & Oxy 5 prn".

On 5/26/16 at 7:44 a.m., registered nurse, (RN)-E stated that on Monday after staff informed her of the situation regarding R8's increased pain, she looked into the incident and found R8 had not received 2 consecutive Fentanyl patch applications on 5/19/16 and 5/22/16. RN-E stated an incident report was filled out and the doctor was called.

On 5/31/16, at 10:03 a.m. the director of nursing (DON) revealed she expected staff to go through the MARs thoroughly and give all medications as ordered. When a patch was placed, the staff was expected to check placement every shift. If they were signing off on placement, they were obviously not checking the date. "We do write the date on any patch that is placed on a resident. These are teachable moments." The DON further stated she recognized the need for staff training in this area. The DON identified the current training consisted of a nursing skills competency during the 3-day orientation on the unit which included medication administration.

R 100 was admitted to facility on 1/14/16, at 6:00 p.m. following a hospital stay for abdominal surgery to remove a pelvic mass related to a diagnosis of elastic ovarian carcinoma (ovarian

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F 309	Continued From page 76 cancer). The Nursing Comprehensive Admission Data Collection and Assessment for R100 was signed and dated 1/14/16, at 6:00 p.m. The assessment identified R100 as alert, oriented and able to communicate her needs. The assessment directed staff to complete the Pain Data and Collection and Assessment however this assessment was not available in her records. An initial admission nursing note written 1/14/16, at 11:00 p.m. identified R100 had an order for Oxycodone 5 mg, 2-3 tablets q 3 hrs prn for pain. A review of the 1/16 MAR showed R100 received Oxycodone HCL 5 mg for severe pain one time on 1/14/16, at 10:45 p.m., however the MAR did not indicate her pain level, the dose or efficacy. A review of the narcotic log from the pharmacy e-kit (emergency kit), revealed that on 1/14/15, 4 tablets of 5 mg Oxycodone were available. R100 received 3 tablets from the e-kit at 10:45 p.m. Early the next morning, at 3:00 a.m. she received the last tablet of Oxycodone from the e-kit. An interview with RN-B on 5/26/16, at 2:04 p.m. verified there were no other logs for Oxycodone in the narcotic book and therefore there was no additional Oxycodone available for R100. Her prescription was not delivered from the pharmacy until the following morning. An Omniview Proof of Delivery receipt confirmed Oxycodone HCL 5 mg, 27 quantity was delivered for R100 on 1/15/16, at 9:21 a.m. A nursing note dated 1/15/16, at 9:05 a.m. stated	F 309		

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F 309	Continued From page 77 "family brought in pts (patient's) own oxycodone tablets to be used for patient." On 5/27/16, the interim director of nursing (IDON) stated she would expect newly admitted residents to have their medications delivered to the facility within 4 hours of admission, especially when Omnicare is a 24 hour pharmacy stating, "When this does not happen staff should contact the pharmacy directly to ensure the delivery would be made in time for pain medications to be available to the resident. There is no documentation that this was done." The IDON further stated that although R100 was admitted on 1/14/16 at 6:00 p.m., the pharmacy did not received the order until 10:00 p.m. as evidenced by the time stamp. She further verified there was no communication made with the pharmacy. She stated there was no evidence that staff completed a pain assessment or assessed her pain level in any manner, "She (R100) was admitted with pain and the only reason we know this is because she was given pain medication twice, at 10:45 p.m. she received 15 mg of Oxycodone and at 3:30 a.m. she received the last tablet (5 mg) from the e-kit." The facility narcotic log book, verified R100 had Oxycodone HCL 5 mg tablet, 27 quantity registers on 1/15/16. No tablets were removed. The facility's 7/15, Admission Process procedure directed staff to initiate the pain assessment as appropriate, but lacked direction regarding obtaining medication from pharmacy in a timely manner for new admissions. The facilty's 3/16, Medication Administration procedure directed staff to "Document the following as applicable: administration of	F 309		

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F 309	Continued From page 78 medication on the MAR as soon as given, indicate refused or omitted by circling initials, indication for refusal or omission on back of MAR or in the nursing progress notes. NOTE: It is not acceptable indicate NA [not applicable] for medications not available from pharmacy. Remove the dose from the back up supply / emergency kit or contact pharmacy or on-call pharmacist and request medication to be sent ASAP [as soon as possible]. If the medication is not available, contact the physician and /or medical director for further orders...indicate reason for administration and effectiveness of PRN medication in the nursing progress notes or on the back of the MAR. The policy for pain management, dated July, 2015, indicated a full assessment included pain origin, location, frequency, type, severity, alleviating factors, exacerbating factors, current treatment and response to treatment. Verbal and non verbal expressions of pain were to be included in the assessment. The policy indicated resident self-reporting as the most reliable indicator of pain. Residents with cognitive impairment would be assessed based on objective The Procedure for Pain Assessment and Management, Effective 7/15, identified: - The primary goal of therapy for acute and persistent pain is to decrease the pain to a tolerable level -Non-pharmacological interventions should be tried as well as pharmacological interventions -Evaluate and document effectiveness of interventions on the Medication Administration record as indicated -Reassess resident status as indicate including	F 309		

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F 309	Continued From page 79 level of pain, side effect management, effectiveness of interventions, need to increase/decrease amount of medication due to tolerance of opioid's and side effects	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to prevent and/or minimize recurring skin breakdown for 1 of 3 residents (R12) reviewed for pressure ulcers. This resulted in actual harm for R12 who acquired two pressure ulcers while in the facility, one of which progressed to a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle), and resulted in the resident being hospitalized. Findings include: R12's Skin Integrity Assessment: Prevention and Treatment Care Plan dated 7/22/15, and current, indicated R12 had a left ankle and right hip wound. Interventions included air mattress on the bed, gel cushion in wheelchair, heels floated,	F 314	1. F12 no longer resides at the facility. 2. Residents that reside at PHR that have the potential for skin breakdown with pressure sores have the potential to be affected by this practice. Current residents with wounds have been comprehensively reassessed for skin risk and Care Plans have been updated as needed. 3. Licensed Nurses have been educated on policy and procedure for wound management. 4. DON/designee will conduct audits of the treatment sheets and skin grids 2 x per week x 4 weeks, then 3 x per month x 3 months. In addition audits of wound documentation will be completed along with MD notification with changes in skin	7/11/16

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F 314	Continued From page 80 pillow between legs, treatments as ordered. R12 was to be turned and repositioned every two hours. Upon admit to the facility R12 was noted to have moisture associated skin damage (MASD) buttocks and groin. According to a skin assessment conducted when R12 was re-admitted from the hospital on 1/27/16, R12 had a sacral ulcer that measured 1.0 by 1.0 centimeter (cm). The wound bed was described as pink and red with no drainage noted. Although no stage was identified, the wound was identified as a pressure ulcer. Skin assessment notes on 2/1/16, indicated the wound had decreased in size to 1.0 by 0.5 by 0.3 in depth with no hip involvement noted at that time. The facility conducted a Tissue Tolerance (TT) Assessment (assessment of the skin's ability to endure the effects of pressure without adverse effects) on 2/19/16. The assessment noted R12 was evaluated after having been in a lying position for two hours. At that time his skin was observed to be "red." The TT assessment indicated the lying time was decreased to one and a half hours and the resident's skin was then observed to be "pink to clear." The sitting portion of the assessment was not completed, so it could not be determined how long R12's tissue could tolerate pressure when the resident was sitting. The summary section was void of any documentation on the back page of the form. However, as noted above, the care plan for skin care indicated that R12 was to be turned and repositioned every two hours. A Care Area Assessment for skin dated 2/23/16, indicated R12 had a history of MASD, and had Calmoseptine ointment (multipurpose moisture	F 314	condition and changes in wound status. 5. DON/designee will forward all reviews of change in condition program and Pain management audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	

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	245083	A. BUILDING _____ B. WING _____	06/01/2016

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barrier) applied following each incontinent episode. A Minimum Data Set (MDS) dated 4/25/16, also indicated R12 had MASD and that R12 was always incontinent of bowel.

The facility utilized a PUSH Tool (a tool that compares total scores measured over time to provide an indication of improvement or deterioration in pressure ulcer healing). The coccyx PUSH Tool dated 3/2/16, indicated the wound area measured less than 0.3 cm by 0.3 cm with granulation and the ulcer had a light exudate. The Skin Grid sheet also dated 3/2/16, indicated the wound measured 0.9 cm by 0.4 cm by 0.2 cm with serous drainage and identified the wound as a stage 3 (Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). Due to this inconsistent wound documentation, the actual measurements of the ulcer could not be determined.

On 3/22/16, the PUSH tool indicated the coccyx ulcer had increased in size to 0.3 to 0.6 cm by 0.3 to 0.6 cm with granulation present, and the ulcer was described as having a light exudate. The Skin Grid worksheet, also dated 3/22/16, noted the wound to 1.0 cm by 0.3 cm by 0.2 cm with serous drainage and described the ulcer as a stage 3. Due to this inconsistent wound documentation, the actual measurements of the ulcer at that time could not be determined. On 3/29/16, the Skin Grid worksheet indicated R12's coccyx ulcer was healed.

The March 2016 Medication Administration Record (MAR) and Treatment Administration

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Record (TAR) identified only one circled treatment, depicting the resident had not received the treatment by facility staff, or that the resident had refused. The one circled treatment was from 3/1/16 when the physician progress notes indicated the wound doctor completed the treatment.

The interdisciplinary Progress Notes from March 2, 2016 at noon, through March 29, 2016 at 4:30 p.m., were reviewed and lacked any documentation to indicate the resident had refused treatment to the ulcers.

The VOHRA wound MD note dated 3/29/16, indicated R12's coccyx area had healed. However, the note indicated R12's right hip and left ankle had deteriorated due to the resident being non-compliant. The notes further indicated the right hip had been debrided and the physician had explained the procedure and reasons for it to the resident on 2/16/16. The medical record documentation lacked any evidence of R12 refusing wound care.

A Skin Assessment dated 4/6/16, indicated R12 had an open area on the right hip with a dressing applied. There was no measurement included on the 4/6/16 Skin Assessment. In addition, the Skin Assessment indicated R12 had an abrasion to the left ankle. There were no measurements of the abrasion. Finally, the Skin Assessment indicated the sacral area was noted to have a, "scar over a bony prominence."

Notes from the VOHRA wound MD dated 4/6/16, indicated no changes to the resident's skin issues on the hip or ankle.

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R12's primary physician's Progress Note dated 4/13/16, indicated the coccyx wound was healed. The note also depicted a wound check had been conducted on 4/6/16 on R12's left ankle and right hip however, there was no further description of the wounds.

There were no further Progress Notes noted in the medical record from R12's primary physician or nurse practitioner (NP) regarding the ulcers. Per an interview with the interim director of nursing (IDON) on 5/29/16, at 3:45 p.m. she stated she was going to call the primary physician to get the Progress Note from his last visit to R12. (That notes faxed to the facility at 4:49 p.m. on 5/29/16 were dated 4/13/16.)

A Progress Note from the VOHRA wound MD dated 4/13/16, indicated R12's right hip had improved and had decreased necrotic tissue. The left ankle had no change.

A Progress Note from the VOHRA wound MD dated 4/20/16, indicated R12's right hip had deteriorated due to a decline in R12's status, but still had decreased necrotic tissue. The Progress Note further indicated R12's left ankle had deteriorated due to the resident's being non-compliant. However, the medical record documentation lacked evidence of the non-compliance or refusals of wound care.

A Skin Assessment dated 4/21/16, indicated R12 was noted to have abrasions and skin tears on both feet in between the toes. However, no further assessment, nor treatment had been established. In addition the Skin Assessment indicated R12 had pressure ulcers to the right hip and coccyx. The open areas between the toes

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F 314	Continued From page 84 were not identified on the current plan of care. Nursing Progress Notes from 4/21/16, were void of any documentation about the areas between the toes being open. The 4/21/16 Nursing Progress Notes also indicated the coccyx ulcer treatment had not been provided as ordered during the day shift as the resident had been up in the chair since 7:00 a.m. however, the Progress Notes indicated the treatment had been done on the evening shift. On 4/27/16, documentation on the Skin Grid form indicated the right hip had tunneling/undermining at the 5 o'clock area and measured 1.2 cm. The area was described as measuring 6.0 cm by 4.0 cm by 0.5 cm. In addition the left ankle ulcer was described as measuring 2.3 cm by 2.5 cm by 0.2 cm and was identified as a Stage 4. Nursing Progress Notes from 4/28/16, indicated the morning skin treatments had not been done however, the MAR for 4/28/16, had been signed off to indicate the treatment had been completed during the evening shift. The Progress Notes from 4/21/16 through 5/11/16, failed to identify the areas between R12's toes as being open, or as skin tears. In additions the notes did not indicate any refusal of care by R12. The VOHRA wound MD note dated 5/4/16, indicated R12's right hip had deteriorated due to R12 being non-compliant with wound care and the left ankle had no change. However, the medical record documentation lacked evidence of any non-compliance including refusals of the wound care. There were nothing in the wound	F 314		

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F 314	Continued From page 85 MD's notes to indicate any treatment had been initiated for the open areas between R12's toes. The VOHRA wound MD note dated 5/10/16, indicated R12's right hip and left ankle had improved. However, the wound MD did indicate in his notes that R12 had incontinence associated dermatitis which had improved. Although R12 had orders for Calmoseptine ointment to be applied every shift, and as needed after each incontinence episode, the March through May 2016 TARs lacked documented evidence of the ointment being used after each incontinence episode. The April 2016 MAR and TAR indicated the daily wound orders were not completed two times. The May 2016 MAR and TAR noted three of the daily hip wound orders were circled, which indicated the wound treatment was not done. Neither the April or May MAR or TAR included any treatments for the areas between R12's toes even though the TAR for April indicated R12's skin was checked for impairment on 4/6, 4/14, 4/20, and 4/27/16. The May TAR noted the May 4th skin check had not been completed at all. The staff were to document a "+" to identify any new areas or a "-" to indicate no new areas. The TAR was void of any identification of a "+" or a "-." R12's open areas /skin tear areas between the toes were not identified on the facility April and May 2016 TARs after being identified on 4/21/16. R12 was admitted to the Veteran's Administration (VA) Hospital on 5/10/16. Upon request by the surveyor, a History and Physical (H&P) dated 5/10/16 was obtained and reviewed. The H&P indicated R12's hospital admission skin	F 314		

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assessment included: right hip presenting with an "unstageable ulcer, non-tender necrotic tissue and possibly palpable acetabulum (a concave surface of the pelvis, the head of the femur meets with the pelvis at the acetabulum) with the appearance of a recently removed wound vac, with Stage II ulcers [partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater] between multiple toes bilaterally, [stage] II-III ulcer on the sacral area, granulation tissue and moist ulcer on left medial malleolus, bandaged, no necrotic tissue, stage III." The resident's hospitalization laboratory results indicated R12 had low albumin measuring 2.4 (the normal range is 3.4 to 5.4 grams per deciliter (g/dL) and the hemoglobin was 9.6 (the normal HGB for a male is 13.8 to 17.2 g/dL). The VA physician had documented: "? [Questionable] Neglect: We will have SW [social worker] look into his case further. This hip wound never should have gotten as far as it did." R12 was to have a wound consult on 5/11/16.

Skin Grid documentation dated 5/11/16, while the resident was hospitalized, indicated R12's right hip had tunneling/undermining at the 5 o'clock area and measured 2.4 cm. The right hip wound measured 6.5 cm by 4.2 cm by 0.8 cm. The area had increased in size since measurements 4/27/16. The left ankle had decreased to 1.8 cm by 1.8 cm by 0 depth.

The VA Wound Consultation Sheet dated 5/11/16, noted R12 had wounds between the 4th and 5th toes on the right foot, and had red and inflamed areas on the buttocks and groin folds. The VA Wound Assessment further indicated the right hip was unstageable and irregular shaped. The area

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was identified as measuring 4.5 cm by 7.7 cm by 1.5 cm. with moderate purulent drainage. The left ankle was identified as having presented as Stage 2 with 80% granulation, with serous fluid present, and as measuring 1.6 cm by 2 cm and shallow. The coccyx wound was identified as unstageable, with 90% adherent tissue and 10% granulation. The area was described as measuring 1.5 cm by 1.5 cm by 0.3 cm with a scant amount of serous drainage. The buttocks was described as having erythema and a rash. Treatments were ordered for all of the areas including the coccyx ulcer which was identified as having been packed with a gauze dressing.

On 6/1/16, a NA (nursing assistant) Detail Report was printed. A question for the NA to answer was "Did you see a new skin problem?" Although the report sheet did not depict which areas of the body the skin was checked for, the answers from 4/27 through 5/10/16, were documented as "No."

On 5/29/16, at 10:40 a.m. RN-A was interviewed and she stated she'd taken care of R12 while he was in the facility. RN-A commented that while R12 had a turning and repositioning schedule for his back and left side only, R12's coccyx had healed. She further stated R12 had used a wound vac on his right hip for a "pretty deep" pressure ulcer. When asked whether she'd had training on how to care for R12's wound using the wound vac she stated, "Not here."

On 6/1/16, at 3:37 p.m. the interim director of nursing (IDON) and nurse consultant RN-B were interviewed. RN-B stated staff were supposed to perform skin checks weekly. She proceeded to explain that staff were to put a "+" or a "-" in the box on the TAR which indicated 'yes' there was a

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F 314	Continued From page 88 skin problem or 'no' there was not. The IDON added that she'd applied the wound vac to R12's hip on 5/9/16, the day before R12 left for the VA Hospital. The IDON said she was uncertain whether R12's coccyx area had been open or not at the time she'd applied the wound vac to his hip. In addition, the IDON stated neither of the nurses who had signed the TARs were still working in the facility. On 6/1/16, at 3:45 p.m. licensed practical nurse (LPN)-B and nursing assistant NA-B were interviewed. They both knew who R12 was but could not describe what skin care had been provided to R12. On 6/2/16, at 12:12 p.m. the NP on call for the resident's primary MD, returned a call the surveyor had placed to the MD. The NP stated she had not seen R12's wounds for a long time because the facility had a wound doctor who made rounds. The NP further confirmed neither she nor the MD had received a call from the facility regarding R12's coccyx wound having re-opened. The facility's Procedure for Pressure Ulcer Prevention/Treatment effective July 2015, directed the staff to "review and revise Skin Integrity Assessment: Prevention and Treatment Care Plan to reflect interventions to heal pressure ulcers and stabilize, reduce or remove underlying risk factors." R12 was harmed as he was re-admitted back to the VA with a new pressure ulcer on the coccyx, between his toes and a right hip ulcer where the bone was palpable.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		7/11/16

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F 315	Continued From page 89 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a medical justification for the ongoing use of an indwelling catheter for 1 of 3 residents (R96) reviewed for catheter use, and to provide timely toileting assistance for 1 of 1 resident (R72) who had urinary odor and was incontinent. Findings include: R96 utilized a Foley catheter for urinary retention according to a registered nurse (RN)-C who was interviewed on 5/23/16, at 5:30 p.m. The resident's 5/13/16 admission Minimum Data Set (MDS), however, did not reflect the use of a Foley catheter. The assessment indicated the resident was cognitively intact and had active diagnoses of anemia, depression and diabetes mellitus. During an interview on 5/25/16, at 10:03 a.m. R96 stated he was currently utilizing a Foley catheter. R96 explained that the time of his admission to the facility he was able to void urine on his own, but then within a few weeks, "I was all plugged	F 315	1. R96 was followed up with urology and catheter has been discontinued. 2. Residents that reside at PHR who have a catheter have the potential to be affected by this practice. A comprehensive bowel and bladder assessment has been completed on residents that have indwelling urinary catheters. Residents that have indwelling urinary catheters have been reviewed to ensure proper diagnosis and care plans are complete. 3. Licensed Staff have been educated on completion of the bowel and bladder assessment, justification and Care Planning of urinary catheters. 4. DON/designee will conduct audits on residents with indwelling catheters to ensure completion of bowel and bladder assessment, proper justification for catheters, and care plans 3 x per week x 4 weeks, then 3 x per month x 3 months. 5. DON/designee will forward all catheter audits to the QAPI committee monthly x 3	

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F 315	Continued From page 90 up. I was not able to urinate so the facility put in a catheter." R96 stated he was unsure what the future plan was related to the catheter, nor whether he had seen a urologist. The same day at 10:53 a.m. a licensed practical nurse (LPN)-B stated R96 was admitted from the emergency room with a diagnosis of urinary retention. LPN-B explained R96 was able to void urine for a few days then we had to straight catheterize him on a regular basis until we received an order to place a Foley catheter. LPN-B was unsure if there were plans for a urologist to assess the problem. A nurse practitioner (NP) dated 5/17/16, indicated R96 was experiencing episodes of urinary retention. The NP ordered a Foley catheter, with a "trial removal in a few days or next week and if unable to void independently refer to urologist." A review of R96's 5/16, nursing notes and medication administration record (MAR) did not reflect direction for nursing staff to begin the trial to remove the catheter. During an interview on 5/25/16, at 2:56 p.m. a registered nurse (RN)-C verified urinary retention should not have been considered medical justification for the ongoing use of an indwelling catheter. RN-C stated she would call R96's NP to clarify the justification for the use of the catheter, and to inquire about the potential need for a urology appointment. The facility's 7/15, Indwelling Urinary Catheters policy indicated all residents with an indwelling catheter required a medical justification for the ongoing use of an indwelling catheter, as well as	F 315	months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	

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F 315	Continued From page 91 a comprehensive assessment and underlying factors that supported the justification of a catheter beyond 14 days.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure measures were implemented that minimized the risk of falls for 1 of 3 residents (R72) who were reviewed for falls. Findings include: R72 had 11 falls between 11/19/15 and 6/25/16 without adequate revision of the care plan. On 11/19/15, at 4:30 am R72 was found on floor with blood on his face and significant amount of blood on the floor. Pressure was applied to a laceration, and his glasses were broken. Blood was also found on roommate footboard, may have hit head. R72 could not state what happened. A follow up report on 11/19/15, indicated to encourage R72 to keep door open, begin physical therapy and use a bed side commode and urinal, and noted R2 as impulsive.	F 323	1. R72 has been comprehensively re-evaluated for falls and Care Plans have been updated. 2. Residents at PHR have the potential to be affected by this practice. Falls are reviewed ty the IDT and a determination of root cause analysis is completed. 3. Staff have been educated on the prevention of accidents, root cause analysis and documentation of interventions. 4. DON/designee will conduct audits on occurrence reports to assure follow up in regards to the event was completed along with assuring Care Plan has been updated with new interventions. 5. DON/designee will forward all occurrence audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	7/11/16

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No commode or urinal was observed in R72's room 5/31/16, at 10:22 a.m. verified a commode or urinal was not used for R72. RN-A verified the resident would try to crawl out of bed so staff go in to talk to him see what he wants, and get him up in chair if he wants. She said he can tell when he has to go to the bathroom.

On 11/21/15, at 8:00 a.m. R72 leaned over to pick up a sugar packet from floor and fell out of the wheelchair hitting his head. The follow up report on 12/17/15, indicated R72 was sent to the emergency room and was admitted to hospital. The report indicated upon return from the hospital R72 started therapy and received a wedge cushion for the wheelchair seat. No wedge cushion was observed in R72's chair during the survey, and RN-C was unaware of wedge cushion use during interview on 5/26/16 at 2:44 p.m.

The fall report for the incident on 12/17/15, indicated R72 fell in his room and that a nursing assistant had taken a break at an inappropriate time. The nursing assistant was re-educated about proper times to take breaks. The report lacked any description of a statement of events by the nurse, resident or witness. The report was not signed indicating proper notifications given or closure of report.

The fall report for 1/15/16, indicated R72 was found at 8:20 p.m. in his room on the floor and was bleeding from his head. R72 was given first aid, the physician and family were notified and was sent to the emergency room. The report lacked signatures indicating the DON, administrator were notified. The report lacked general follow up documentation for root cause,

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investigation, and care plan updates. Nursing progress notes concerning the fall were first completed on 1/6/16, at 6:30 a.m. when R72 returned from the hospital. R72 had sutures applied to his forehead. Starting at 1:00 p.m. R72 was assessed for vital signs and neurological symptoms every four hours. At 9:00 p.m. 1/16/16, a progress note indicated R72 was confused, difficult to re-direct and required 1:1 staff for safety. A progress note on 1/18/16, at 9 p.m. indicated the continued need for 1:1 staff assistance for safety as he had unsteady gait and would stand up from his wheelchair. The next nursing progress note was completed on 1/21/16 concerning follow-up from a medical appointment.

The fall report for 2/17/16, indicated R72 was found lying on the floor in his room. R72 said he had slipped, fell and gotten himself back up. No injuries noted. The report indicated R72 had signs in his room to remind him to ask for help, but did not due to cognitive issues. The director of nursing (DON) and administrator had been notified of the event, but the report lacked signatures.

The fall report for 5/4/16, indicated R72 had a laceration above there right eye and a bruise under the right eye. R72 said he tried to go to the bathroom. The report indicated R72 was found partially off his bed. The report lacked a follow-up and signatures indicating proper notification had been given to administrative staff. The nursing notes for 5/4/16, indicated 72 stated he fell and had gotten himself back up. An Interdisciplinary team (IDT) note indicated a review of the fall with implementation of a mesh stop sign on the bathroom door.

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F 323	Continued From page 94 The fall report for 5/12/16, indicated R72 was found sitting in from of nightstand. The follow-up documentation indicated pain and or constipation might have lead to R72's up and down behavior. R72 was placed on frequent observation. Nursing documentation on 5/12/16, indicated R was seen in the hallway at 8:05 a.m. and then was hollering from his room at approximately 8:10 a.m. and was found on the floor. The 5/16/16, fall report indicated R72 was self-transferring and fell, no injuries. Nursing documentation for 5/12/16, indicated a facility volunteer witnessed R72 fall when passing by his room. R72 stated he fell. General follow-up documentation was missing from the report. The 5/17/16, fall report indicated R72 was walking in his room when he lost his balance and fell. R72 stated he fell. General follow-up documentation was missing from the report. A nursing note from 5/17/16, indicated the nurse practitioner (NP) was consulted about the status of falls. The note In indicated the NP had done labs, ordered therapies and reviewed meds. The NP would like to have therapy continue to work with R72. Nursing interventions included follow up of toileting, stop sign for bathroom and anti tip bars on wheelchair. Ortho blood pressures were to be checked. Seroquel (antipsychotic) was reviewed and NP continued the order. R72 was placed on 1:1 staffing after the fall but did not indicate for how long. On 5/25/16, R72 was found in bed after roommate reported R72 had fallen. R reported pain to his knee but could not say if he had fallen. An x-ray was ordered and the Seroquel was	F 323		

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decreased. On 5/26/16, R72 reached for a cookie and fell forward out of his wheelchair.

The director of rehabilitation was interviewed on 05/26/2016 9:27 a.m. She said R72 had been seen by therapy 6 times since July 2015 due to a number of falls and R72 was currently receiving therapy. Physical therapy was evaluating mobility due to a recent decline cognition and providing strengthening exercises and reassessing appropriateness of range of motion exercises. She explained when R72 first came in he used a walker with cues. As of now does not have cognitive skills to use walker on his own. She was not aware if a wedge cushion was being used. The mobility care plan dated 9/11/15, indicate occupational therapy to change the wheelchair cushion for R72 with a 2" shorter depth for better positioning.

The interim director of nursing (IDON) was interviewed 5/26/16, at 11:09 a.m. She said the facility had become aware that fall incident reports had not been followed up adequately and had not been completed. She explained the new process for completing fall investigation. The nurse was expected to do an initial reporting via the electronic health record. The nurse manager and the interdisciplinary team (IDT) would investigate, review interventions and update the care plan with the expectation to follow up and close within 5 days. Each mooring at triage meeting of the DON, therapy administrator and the Minimum Data Set (MDS) nurse would report incidents from previous day. The DON would report findings to the nurse managers. In the afternoon a "cool down" meeting would be held with nurse managers to go over the day and what discussed in the morning to make sure all items

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were followed up. The DON said the system had been in place for about 2 weeks and the facility had reviewed previous incidents for review and completion.

The care area assessment for falls dated 12/1/15, indicated R72 had a history of falls and required occasional assist with mobility and had impaired balance during transitions. The analysis of findings did not specify any conclusions about the root causes or contributing factors related to falls, such as needing to use the toilet, medications, location and time of day. The assessment indicated the need for staff assistance with toileting, ambulation.

The fall/injury assessment: prevention and management (FIAPM) care plan (multiple dates) was used as the assessment of falls. The document listed multiple fall incidents and that R72 was at risk for fall related to pain, unsteady, weakness, dementia, cardiac disease, visual and hearing issues and use of an antipsychotic medication. The goal was: will be free of a serious injury if a fall would occur. The document contained multiple hand written interventions, some of which were temporary or completed. It was un-clear from reading the document what the current interventions were to help R72 from having further falls.

The FIAPM care plan was reviewed with RN-B on 5/26/16, at 2:44 p.m. RN-B verified the care plan was difficcult to read due to multiple hand written updates making it hard to follow. RN-B said the current interventions to her understanding were: physical therapy , gripper socks, de-clutter room, anti-rollback on wheelchair, stop sign on bathroom door, decreased Seroquel, and

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F 323	Continued From page 97 supervision with ambulation, RN-B said she had recently put R72 on a toileting schedule to include upon rising, before and after meals and bedtime. R72 was also to sit at the nursing station to keep eye on him. RN-B was not in favor of a low bed or mat on the floor. RN-B was not aware of a wedge cushion being used. The east nursing unit group 1 care sheet was provided on survey. The sheet listed had R72 fall preventions of grippie socks. The fall policy, dated July, 2015, indicated proper action following a fall included determining what may have caused of contributed to the fall, initiate and complete the accident incident process, communicate interventions to the staff using the Fall/Injury Assessment:Prevention Management Care Plan.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		7/11/16

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F 329	Continued From page 98 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication was administered only with adequate indications and with appropriate monitoring for 3 of 6 residents (R78, R31, R72) whose medications were reviewed. Findings include: R78 was interviewed on 5/20/16, at 2:15 p.m. regarding his pain level and pain medication. He reported he stayed up until about 3:00 a.m. because of pain in his feet which he rubbed for relief. He received pain medication prior to dressing changes and every four hours as needed (PRN). R78 also explained he did not always get routine pain medication, only if the dressings to his toes were changed. If he declined the treatment, he did not get the two pain pills. R78 reported, "I can't have PRNs--well, sometimes I do. I'm supposed to get it but I don't. Well, sometimes I do get two at 8:00. I can get them every four hours PRN. I get two just before bandage treatments in the morning." If he went to the wound clinic, "then they don't do them [wound treatments] here." Sometimes I have it at 9 and 10, [medication followed by wound treatment] 8 and 9 or 10, and 7 or 8 only before bandage changes. If I don't trust the staff I don't let them	F 329	1. R31 no longer resides at the facility. R78 and R72 was comprehensively re-assessed for pain and Care Plan revised to ensure medication that is administered has adequate indication and appropriate monitoring. 2. Resident at PHR have the potential to be affected by this practice. Residents that experience pain Care Plans have been reviewed and updated to reflect appropriate pain management as well as adequate indications and appropriate monitoring. The physician has been updated and care plans reflect changes as needed. 3. Licensed nurses have been educated on pain management, documentation of administering a pain medication, and resident refusals of medications/treatments. 4. DON/designee will conduct audits of PRN medication and follow up on effectiveness, documentation of efficacy and physicians orders 3 x per week x 4 weeks x 3 months. 5. DON/designee will forward all pain medication audits to the QAPI committee monthly x 3 months for continued	

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F 329	Continued From page 99 do the dressing changes." R78 reported he was just leaving for the wound clinic and stated, "This time they're going to use the knife [surgically removing tissue] which I am not looking forward to." R78's 4/5/16, Minimum Data Set (MDS) assessment indicated the resident had generally intact cognition and diagnoses including schizophrenia and peripheral vascular disease. Dressings were applied to two venous/arterial wounds on his foot. At the time of the assessment R78 experienced frequent pain he rated at three (10 being the worst) that made it hard to sleep at night, but did not limit his daily activities. He was prescribed scheduled and as needed (PRN) pain medication. The medication administration record (MAR), narcotic book, and nursing notes were reviewed from 5/1 to 5/27/16 and the following was noted: 1) Physician's orders for R78 included Oxycodone HCL (narcotic pain medication) 5 milligrams (mg) two tablets twice daily before dressing changes and 5 mg every four hours PRN for pain rated 8-10. Orders also included Lidocaine 2% gel (numbing agent) topically to foot wounds twice daily with dressing changes, and Naproxen 500 mg twice daily (anti-inflammatory). 2) The MAR directed staff to ask the resident, "Is you pain program effective for you? If not provide pain rating using the Wong-Baker pain rating" (facial descriptors with 0-10 ratings, 10 being the worst pain). Twice daily staff documented the resident reported his pain program was effective. 3) Another order on the MAR read, "Notify	F 329	opportunities for quality improvement. 6. Completion date: July 11th 2016	

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MD/NP" (medical doctor/nurse practitioner) if the resident refused the twice daily dressing changes to his feet. The order was initialed 16 of 53 times with 5/2/16 initialed and circled. There was no explanation on the MAR to explain whether the initials indicated the resident refused the dressing changes one time or 19 times, or whether the staff was simply acknowledging they noted the physician's order.

4) Oxycodone 10 mg was documented as given twice daily everyday, with the exception of 5/3/16. Although was no explanation on the MAR, a nursing note reveled the resident declined the evening wound treatment.

5) A nurse's note dated 5/14/16, at 1:00 p.m. indicated the resident refused wound care and was requesting Oxycodone. Although wound care was not performed, the narcotic book showed the resident was administered Oxycodone 10 mg at 8:00 a.m., no medication at 1:00 per the resident's request, and then 10 mg again at 8:00 p.m.

6) On 5/20/16, when R78 was interviewed and was on his way to the wound clinic, the narcotic book indicated the pain medication Oxycodone 10 milligrams (mg) was administered at 12:30 p.m. in addition to five PRN doses that day. However, the medication administration record (MAR) noted 10 mg was given at 8:00 a.m. and 8:00 p.m.

7) Although a nursing note on 5/21/16, at 10:30 a.m. revealed the nurse "has been attempting to arouse resident to give him his pain medicine and do his wound care. Unable to awaken him" the narcotic book showed Oxycodone 10 mg was

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F 329	Continued From page 101 administered at 10:30 a.m. 8) Various orders related to twice daily dressing changes were signed off, sometimes were left blank, and sometimes were circled, but only three days included an explanation (unable to get treatment done, refused treatment, and wound clinic). Although it was unclear whether the wound treatment was completed those shifts, Oxycodone was consistently signed off as administered. 9) Documentation on the MAR indicated PRN doses of Oxycodone were also administered, however, no explanation was provided showing the resident rated his pain at 8, 9 or 10. Two days the the resident rated his pain at 7, however, the Oxycodone was administered anyway. Non-pharmacological interventions of positioning and distraction were only noted four times in the month. The efficacy of the PRN medication was only documented twice. 10) The narcotic book revealed R78's Oxycodone was administered at a significantly greater frequency than was reflected on the MAR. In fact, the narcotic book initialed R78 was administered Oxycodone between 2-7 times daily, with 3-9 pills administered per day. The narcotic book reflected 162 pills were administered however, the MAR reflected 100. The interim director of nursing (IDON) was interviewed on 6/1/16, at 8:33 a.m. She explained the staff needed to inform the physician as to R78's pain scale ratings if it is lower, but is asking for PRN Oxycodone for pain rated at 7. The IDON said R78 had a history of refusing dressing changes to his feet, and believed it was more	F 329		

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frequently than noted. When asked why staff initialed calls to the MD/NP for refusals the IDON replied, "I'm hoping there would be a note. I can see where that would be confusing. Maybe we should word it differently and say did he refuse 'yes' or 'no'?" The IDON thought the resident went frequently to the wound clinic (documented five times from 5/1 to 5/27/16 in nurses' notes). Regarding how staff knew whether/when to pre-medicate the resident prior to visits to the wound clinic and whether to then hold the treatment the IDON responded, "Yeah--so we should get that order clarified--that's a good question." When asked about issues related to documentation regarding pain and pain medications on the MAR and narcotic books the IDON stated, "We have a lot of opportunities to improve. They are not consistently signing out the meds or indicating a pain rating."

R31 had a significant event with severe edema (excess fluid in the tissue) of her legs leading to fluid weeping from her legs. Medication orders that may have contributed to the edema were not correctly documented for proper physician notification.

On 5/24/16, at 10:29 a.m. a family member (F)-C was interviewed and explained the course of events leading up to R31's edema. F-C explained at the time of admission on 4/21/16, R31 was walking, eating and was mentally alert. F-C believed staff were supposed to have been elevating the resident's legs at all times due to the edema. However, when F-C visited daily she found R31's legs were not elevated. F-C stated it was "a struggle" to get a recliner that worked

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properly to keep R31's legs up.

When F-A arrived for her daily visit on 5/20/16, R31 was sitting in the recliner with legs down. R31's legs were very swollen, her pant legs and socks were wet and there was a puddle of fluid on the floor by her feet, and the resident was confused. F-C quickly notified the staff of the situation, was upset, and requested to file a formal complaint.

On 5/25/16, at 7:18 a.m. a nursing assistant (NA)-C was observed assisting R31. NA-C asked R31 if she would like to put her feet up. R31 initially declined, but, then agreed to put feet up with encouragement.

The Comprehensive Admission Data collection and Assessment, dated 4/21/16, indicated no edema was present. A nursing noted, dated 4/24/16, indicated R31 had 2+ pitting edema (a situation in which the swelling is severe enough to leave a dent in the skin for 10 to 15 seconds when pressed with the finger). On 4/25/16, a nursing note again identified 2+ pitting edema. The 4/16 medical administration record (MAR) indicated 2+ edema from 4/24/16 through 4/30/16.

An admission physician (MD) progress note dated 4/27/16, noted no edema. The progress note included diagnoses that could have contributed to edema including chronic kidney disease stage 3 and congestive heart failure. The plan was to continue to monitor.

On 5/2/16, nursing notes again reflected bilateral edema of all four extremities as well as wheezing. The degree of edema was not indicated. The MD

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was notified, and telephone orders dated 5/2/16, indicated a diagnosis of wheezing with orders for in house psychology, and a medication to help with breathing. The edema was not addressed.

On 5/3/16, a telephone order was written for 1 gram of sodium and restricted fluids both for seven days due to R31's low sodium. On 5/12/16, a nurse practitioner (NP)-A's note indicated 1+ edema. On 5/13/16, a nursing note indicated 1+ edema of the lower extremities and R31 was encouraged to keep feet elevated. On 5/16/16 a nursing note indicated R31 had a weight gain over two pounds in two days with "ongoing 2+ pitting edema" and NP-A was notified. The MAR for 5/16, included an order for sodium 1 gram daily for 14 days dated 5/10/16. It was unclear whether the MD was aware of the order, as there was no corresponding signed telephone order.

A telephone order, dated 5/16/16, indicated a diagnosis of anxiety with anxiety medication ordered. On 5/19/16, a nursing note indicated 2+ bilateral edema and the resident was being encouraged to elevate her legs. On 5/20/16, "writer called physician" but the note did not indicate the purpose for the call. The notes lacked any description of the events on 5/20/16, as reported by F-C, including fluid weeping from her legs and F-C's report to the nursing staff. The record also lacked any on going tracking of the level of edema and/or fluid weeping from the legs after 5/20/16. However, NP-A did discontinue the sodium pill, wrote orders to keep resident in bed with lower extremities elevated, and increased a medication to help relieve fluid build up.

NP-A's visit note of 5/20/16 indicated R31 was seen for a change of condition. R31 was in

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reclining chair alert only to stimuli which was a significant change to previous level of consciousness. R31's legs were swollen, but not pitting, weeping moderate amounts of fluid. The note indicated F-C had reported R31 said she "was 'ready to die.'"

On 5/26/16, at 2:10 p.m. RN-C reported regarding R31, "If her legs are down they will swell up."

NP-A was interviewed on 5/31/16, at 12:30 p.m. and explained the events of 5/20/15. NP-A stated F-C found R31 with swollen legs and fluid weeping from the legs. NP-A made a visit that day and found the resident's significant change in condition. Medication was increased to remove excess fluid with good results and R31 had since been more alert. NP-A stated every time she saw R31 she had edema and although it was not documented, would have been surprised the edema was not present at the time of the resident's admission to the facility. When asked about administering sodium when edema was present NP-A verified it could have worsened the edema, but she had been more concerned with the low sodium levels. NP-A verified she had not notified the MD about R31's weeping legs and she had discontinued the sodium.

On 6/1/16, at 10:00 a.m. the primary MD was interviewed. She verified the sodium could have contributed to edema and said, "It now makes more sense now about her drastic change in her legs with the extra sodium." The MD also verified R31's sodium levels could have been low due to her diagnosis of congestive heart failure with edema.

The facility's 7/15, Notification of Resident

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Change in Condition policy indicated "facility clinicians will immediately inform the physician and resident's legal representative when there is a significant change in physical, mental, or psychosocial status." Documentation was to be completed in the nursing progress notes the time notification was given.

R72 had chronic pain without adequate assessment, documentation, and implementation of non-pharmacological interventions.

On 5/24/16, at 8:30 a.m. R72 was observed sitting in his wheelchair in the hall way. He winced, pointed to his shoulder and said he had pain. R72 was observed later the same day at 7:30 a.m. Licensed Practical Nurse (LPN)-B attended to R72 who had been calling out for help. LPN-B asked if in pain and R72 replied, "yes". LPN-B then offered to get something for pain. At 8 a.m. LPN-B returned to assess pain in shoulders and knee. LPN-B asks R72 to rate the pain. R72 could not rate the pain but could say yes to when and where it hurt during the assessment while LPN-B gently moved R72's arms and legs.

On 5/27/16, at 9:41 a.m. R72 was lying in bed. He grimaced while the surveyor spoke to the resident. When asked if he was experiencing pain he replied, "Well yes." When asked where he placed his hand on the right side of his neck and stated, "Right here--in my neck. He then moved his hand up on his head behind his right ear and stated, "And up here. It always hurts." The RN-D was informed of R72's complaints of pain and said he does sometimes complain of pain. R72 was prescribed scheduled Tramadol and "maybe he didn't get it yet or it didn't kick in yet," but said

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she would check on it. On 5/27/16, at 10:30 a.m. treatment sheets revealed the resident could have been administered Ben Gay topical pain cream but it had not been administered at all during the month.

A pain assessment was completed on, 5/12/16. The assessment lacked input from R72. The resident interview section of the assessment was blank. The instructions were to attempt the interview, but, if the resident was unable to communicate answers, skip to section PAIN section for residents with dementia or non-interviewable. The PAIN section indicated R72 had repeated troubled calling out, loud moaning or groaning and crying, and facial grimace. The assessment lacked a description by the nurse of observed pain location, history, or frequency. The follow up plan was to notify the nurse practitioner. R72 had also experienced a fall on 5/12/16, at 8 a.m.

The care plan for R72 indicated a problem with persistent chronic pain. The goal was for R72 to report pain relief within 30-60 minutes of receiving pain medication or treatment; no complaints of pain when questioned; no vocalization of pain; no non-verbal signs of pain; no decline in activity; non-pharmacological measures used and no increase in behaviors. Interventions included monitor and record effectiveness of medication, assess for verbal and non-verbal signs and symptoms of pain unrelieved by treatments, and comfort measures of position change and relaxation techniques.

An order was made on 4/7/16, for Tramadol (a medication used to treat pain) changed from 50 milligrams (mg) three time daily PRN (as needed)

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to a scheduled dose of 25 mg every morning, 50 mg at bedtime and a dose of 50 mg available twice daily PRN. However, the Medication Administration Record (MAR) showed the PRN Tramadol had been used only once between 4/1/16 to 4/7/16. On 5/13/16, the Tramadol was increased to 50 mg 3 times per day with 50 mg available as needed 2 times per day. However, the PRN Tramadol had not been used at all between 4/8/16 to 5/13/16. The MARs for both April and May lacked documentation of the pain location, rating or effectiveness of the administered PRN Tramadol. The daily shift documentation for pain on the MAR indicated the pain program was effective. BenGay ointment could be used for pain three time per day as needed. The BenGay had not been used during April or May, 2016. The MAR lacked any indication for the use of non-pharmacological interventions.

R72's primary physician was interviewed on 05/31/16, at 11:10 a.m. She explained sometimes there would be an increase to pain medication even though the PRN medications had not been tried first. She explained this may happen when the resident does not have the cognitive skill to say he has pain or to ask for the medication. She verified, to her recollection, nursing was not calling about pain. The medication was increased based on physical exam. Also, behaviors can be a manifestation of pain, and R72 did have some disruptive behaviors.

On 4/26/16, an order was made by a nurse practitioner (NP)-B to document daily on R72's behaviors. The order was to document how frequent, time of occurrence, document on MAR

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and in progress notes, and update NP-B in one week. Review of the April and May MAR's revealed no daily documentation of behaviors. Daily progress notes were completed from 4/27/16 to 5/1/16, but lacked notes for 5/2/16 and 5/3/16.

NP-B was interviewed on 5/27/16, 9:47 a.m. NP-B said R72 had degenerative joint disease (arthritis) with pain in the knee, and had frequent falls. NP-B explained she made the determination to change R72's pain medicaiton based on nursing giving information of more pain and that R72 was in more pain. NP-B also assessed R72 by moving his extremities to see when he grimaced, and determined he had pain in his knee. NP-B verified she was not aware of PRN use as "that's a nursing thing". NP-B was also not aware of specific non pharmacological interventions as that would also "be a nursing thing." NP-B said nursing could offer ice or re-positioning.

A registered nurse (RN)-C was interviewed on 5/27/16 8:47 a.m. She explained pain assessments were completed on admission, quarterly and with a change in condition. RN- C explained the nurse practitioner or physician were to be notified if a resident had an increase in pain so they could evaluate.

During interview on 5/27/16 10:14 a.m. A-R said R72's shoulders hurt and she tried to give a massage, but it hurt just to touch so she stopped the massage and notified the nurse of the pain. NA-R said she could use ice on R72's knee.

The policy for pain management, dated July, 2015, indicated a full assessment included pain

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F 329	Continued From page 110 origin, location, frequency, type, severity, alleviating factors, exacerbating factors, current treatment and response to treatment. Verbal and non verbal expressions of pain were to be included in the assessment. The policy indicated resident self-reporting as the most reliable indicator of pain. Residents with cognitive impairment would be assessed based on objective clinical assessments, use of a "proxy" pain reporting and behavioral characteristics. The interdisciplinary team would work with the resident and significant others to establish a care plan that would address the individual's goals for comfort and function. The policy also indicated when medication is indicated, the goal will be to provide satisfactory pain relief by using the lowest possible dose of a medication.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were given per physician orders 8 of 10 residents (R8, R32, R100, R49, R17, R61, R69, R42) reviewed for potentially significant medication errors. Findings include: R8 was observed while seated in a wheelchair in her room on 5/23/16, at 2:22 p.m. She had labored breathing and was moaning. She had a	F 333	1. R100, R17, R61, and R49 no longer reside at the facility. 2. Residents that reside at PHR have the potential to be affected by this practice. The policy and procedure was reviewed for medication administration, medication errors including when to notify the pharmacy, and transcribing medication, and administering Coumadin therapy. 3. Licensed nurses have been educated on medication administration, medication errors,; including when to notify the	7/11/16

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F 333	Continued From page 111 pained facial grimace. When asked if she was in pain she nodded and moved her hand up and down her left thigh and hip area. The therapeutic recreation director entered the room and explained that she had been in an activity but was brought back to her room because she was seemingly in pain. He stated staff was planning to assist her to lie down and administer her pain medication. R8's current physician orders included the following medications: Hydromorphone HCL1 milligram (mg) every (q) morning for pain, Fentanyl C2 75 micrograms (mcg)/hour patch changed every 72 hours (medication has boxed warning), Mypap Arthritis Pain 650 mg tablet extended relief one tablet three times daily (TID), Gabapentin 1000 mg TID for neuropathy (nerve pain), and Hydromorphone HCL1 mg every evening as needed for pain (PRN), and acetaminophen (Tylenol) 650 mg every 4 hours PRN. The 5/16, medication administration record (MAR) revealed R8's Fentanyl patch was not administered on two consecutive occasions, 5/19/16 and 5/22/16 (six days). Although Hydromorphone HCL1 mg PRN was administered on 5/24/16, a reason and efficacy of the medication was not noted as evidenced by a non-described "Medication Note" on the reverse side of the MAR. The Individual Narcotic Record on Page 26 for R8 revealed Fentanyl 75 mcg/hr Patch was received 4/29/16 quantity five was given on 5/13/16, 5/16/16 and 5/23/16. An interview on 5/26/16, at 7:44 a.m. an interim	F 333	pharmacy, and transcribing medications. 4. DON/designee will forward all medication administration audits as well as medication documentation audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	

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registered nurse (RN)-E stated that on "Monday" (5/23/16) after staff informed her of R8's increased pain, she looked into the incident an found R8 had not received two consecutive Fentanyl patch applications on 5/19/16 and 5/22/16 during the evening shifts. RN-E stated an incident report was filled out and the physician was notified.

An interview with the director of nursing on 5/31/16, at 10:03 a.m. revealed the expectation was that staff reviewed the MARs thoroughly and administered all medications as ordered. When a pain patch was placed on a resident, the staff was also expected to check to see that the patch was intact every shift. The DON said if staff were signing off on placement, they were obviously not checking the date. "We do write the date on any patch that is placed on a resident. These are teachable moments." She further stated she recognized the need for related staff training, and confirmed current training included of a nursing skills competency during the three-day orientation on the unit which included medication administration.

R32 admitted to the facility in 2011 with diagnoses including other persistent mental disorder, major depressive and general anxiety disorders, as well as dementia with behavioral disturbance.

On 6/1/16, a review of R32's 5/16 MAR revealed the following:

1) Risperidone (antipsychotic) 0.25 mg was not administered on 5/7, 8, 9, and 31, as the medication was "not available." On 5/24 and 5/30, the MAR was not initialed, however, a

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reason was not noted on the reverse side of the MAR.
2) Neurontin (for nerve pain) 600 mg was not initialed as administered on 5/6, 7, 8, 9, 12, 13, 17, 22, 23, 24, 27, 30, or 31. The medication was circled on 5/20/16 but the reason was not indicated on the MAR.
3) Latanoprost 0.0005% drops (for glaucoma) was not initialed 5/3, 4, 5, 6, 14, or 27, and was circled without explanation on 5/9 and 5/10.
4) Duloxetine HCL (anti-depressant) 20 mg daily was initialed and circled on 5/9, 20, and 31, however, a reason was not noted on the MAR.
5) Ativan (for anxiety) 0.5 mg twice daily was ordered 5/4/16. The MAR was not initialed indicating the medication was administered for the 4:00 p.m. doses on 5/6, 10, 27, or 31. No rationale was noted on the MAR.
6) Brimonidine Tartrate 0.2% (for glaucoma) was initialed and circled on 5/1, 3, 4, 5, 8, 9, 13, 14, 15, 20, 21, 22, and 25. The reason was not noted on the MAR
7) Azopt 1% drops (for glaucoma) was initialed and circled 5/1, 3, 4, 13, 14, 15, and 17, 2016. A reason was not noted on the MAR.
8) PRN Ativan 0.25 mg was administered 5/7, 11, 13, and 14, but non-pharmacological interventions attempted and failed, a reason for administration of the medication, and the efficacy was not noted on the MAR.

R 100 was admitted to facility for fewer than 24 hours on 1/14/16, at 6:00 p.m. following a hospital stay for abdominal surgery to remove a pelvis mass. An initial admission nursing note written 1/14/16, at 11:00 p.m. verified R100 had an order for Oxycodone 5 mg, 2-3 tablets every three hours PRN for pain. A note written at 5:00 a.m. stated "Resident slept. Received prn oxycodone

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twice. Oriented. Fluids offered. Taken well." R100 was discharged from the facility on 1/15/16, at 11:30 a.m. at resident/family request.

An anonymous complaint was received on 1/19/16, by the Office of Health Facility Complaints alleging R100 did not receive adequate pain medication, resulting in "unbearable pain for an extended amount of time."

The 1/16 MAR indicated R100 received Oxycodone HCL 5 mg for severe pain once on 1/14/16, at 10:45 p.m. Documentation, however, did not reflect the resident's pain level, the dose, or efficacy of the PRN medication.

A review of the narcotic log from the pharmacy e-kit (emergency kit), page 21, revealed that on 1/14/15, four tablets of 5 mg Oxycodone were available in the e-kit. R100 received three tablets from the e-kit at 10:45 p.m. Early the next morning, at 3:00 a.m. she received the last tablet of Oxycodone from the e-kit. A nursing note dated 1/15/16, at 9:05 a.m. revealed "Family brought in pts [patient's] own oxycodone tablets to be used for patient."

An Omniview Proof of Delivery receipt confirmed 27 Oxycodone HCL 5 mg was delivered for R100 on 1/15/16, at 9:21 a.m. The narcotic log book, page 63, verified R100 had Oxycodone HCL 5 mg tablet, 27 quantity registers on 1/15/16. No tablets were removed.

An interview with the nurse consultant (RN)-B on 5/26/16, at 2:04 p.m. verified no additional Oxycodone was logged in the narcotic book, therefore no additional Oxycodone had been

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available for R100 since her prescription had not been delivered from the pharmacy until the following morning.

During an interview on 5/27/16, the interim director of nursing (IDON) stated she would have expected newly admitted residents to have their medications delivered to the facility within four hours of admission, especially when Omnicare was a 24-hour pharmacy. The IDON stated, "When this does not happen staff should contact the pharmacy directly to ensure the delivery would be made in time for pain medications to be available to the resident. There is no documentation that this was done." The IDON explained that although R100 was admitted on 1/14/16 at 6:00 p.m., the pharmacy did not received the order from the facility until 10:00 p.m. as evidenced by the time stamp. She further verified there was no communication made with the pharmacy, nor evidence the staff completed a pain assessment to determine the resident's pain level in any manner "She was admitted with pain and the only reason we know this is because she was given pain medication twice. At 10:45 p.m. she received 15 mg of Oxycodone and at 3:30 a.m. she received the last tablet [5 mg] from the e-kit."

The facility's 7/15, Procedure for the Admission Process directed staff to initiate the pain assessment as appropriate but lacked direction regarding obtaining medication from pharmacy in a timely manner for new admissions.

The facility's 3/16, Procedure: Medication Administration directed staff to "document the following as applicable: administration of medication on the MAR as soon as given,

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indicate refused or omitted by circling initials, indication for refusal or omission on back of MAR or in the nursing progress notes. NOTE: It is not acceptable indicate NA [not applicable] for medications not available from pharmacy. Remove the dose from the back up supply/emergency kit or contact pharmacy or on-call pharmacist and request medication to be sent ASAP [as soon as possible]. If the medication is not available, contact the physician and/or medical director for further orders...Indicate reason for administration and effectiveness of PRN medication in the nursing progress notes or on the back of the MAR."

R49 was observed walking in the hallway at 8:15 a.m. on 5/25/16. The resident was observed to have a deflated (empty) IV infusion ball still attached to his peripherally inserted central catheter line (used to administer IV fluids or medications) in his upper arm. During the observation, R49 had a great amount of difficulty adjusting the empty infusion ball hanging down from his arm, and tried unsuccessfully on multiple occasions to tuck the infusion ball into his shirt pocket.

During interview with R49 at 8:28 a.m. on 5/25/16, R49 reported as he pointed to the empty infusion ball, "This has been on since 2:00 p.m. yesterday [5/24/16] and I slept with it." R49 further explained, the nursing staff had not flushed the medication line when the antibiotic was finished running, nor had the nurse administered the second antibiotic (ceftriaxone) as ordered. A registered nurse (RN)-C was in the room while R49 explained the situation. RN-C checked the empty infusion ball and verified it was vancomycin from the previous day, just as R49 described.

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R49's medication administration record (MAR) for 5/16, indicated R49 was to receive ceftriaxone 2 milligrams (mg) infused intravenously at 100 milliliters (ml)/hour once daily at 6:00 p.m. and vancomycin 1500 mg once daily at 2:00 p.m. with normal saline (NS) flushes 10 ml before and after each IV dose. R49's MAR did not reflect staff initials indicating the antibiotic medications had been administered and normal saline flushes provided at 6:00 p.m. as ordered by the physician. R49's physician orders were to maintain his IV with the saline, antibiotic then saline (SAS) protocol.

The same day at 8:26 a.m. a licensed practical nurse (LPN)-B verified he had not started R49's vancomycin that morning, and explained, "I only put his vancomycin on at 2:00 p.m. so that's when I will be doing it today."

During an interview on 5/25/16, at 9:02 a.m. a nursing instructor (NI)-A and a nursing student (NS)-A caring for R49 that morning verified he was already dressed when they arrived at the facility around 6:35 a.m. Both verified R49 had the empty infusion ball of antibiotic still attached to his PICC line that morning when they arrived.

At 9:05 a.m. the interim director of nursing (IDON) then verified R49 was to received both antibiotics one at 2:00 p.m. and one at 6:00 p.m. but had not received the antibiotic of ceftriaxone nor the normal saline flush since the previous day, 5/24/16. The IDON stated the evening nurse was responsible for ensuring medication was administered as scheduled, and a medication error form would be filled out.

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F 333	Continued From page 118 On 5/25/16, at 2:43 p.m. RN-D was interviewed by RN-C and the surveyor. RN-D verified she was the evening nurse responsible for administering medications to R49 on 5/24/16. RN-D reported she was aware the resident was prescribed two different IV antibiotics. RN-D explained R49 vancomycin had been started by the day staff. When she was in the resident's room she had time, so flushed the resident's tube with normal saline. "I noticed there was still some vancomycin antibiotic left in the infusion ball so after I flushed the PICC line I re-attached the antibiotic infusion ball to his [R49's] PICC line." RN-D verified she had not administered R49 his second antibiotic of ceftriaxone nor the normal saline flush at 6:00 p.m. RN-C then instructed RN-D she was to flush the tubing following the medication administration and just prior to administering the second medication. RN-C stated she expected staff to follow the physician's orders and administer medications on time. RN-C stated the nursing staff was directed to use standards of nursing practice by referencing the Mosby's Medical Dictionary, 9th edition 2009, Elsevier and Lippincott Williams & Wilkins Manual Of Nursing Practice 8th edition which were available at the nursing station. The facility's 3/16, Medication Administration policy directed licensed nurses/or trained medication aides to administer medications according to State specific regulation and follow the Six Rights of medication administration. A 7/15, Intravenous Medication policy directed staff to reference standards of practice in Lippincott's Nursing Drug Guide and Omnicare IV Nursing Manual.	F 333		

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R17's physician's orders dated 5/23/16, is to give R17 "potassium [for potassium deficiency and essential for the proper functioning of the heart, kidneys, muscles, nerves, and digestive system] 20 meq two times a day for 3 days and recheck potassium on Friday" (5/27/16). The 5/16 MAR was reviewed on 5/31/16, at 11:20 a.m., and revealed the resident instead received the potassium twice daily from 5/24/16 to 5/31/16, a total of eight days.

The interim director of nursing (IDON) and surveyor reviewed R17's orders, MAR, and medication cards on 5/31/16, at 2:27 p.m. The IDON verified R17 should have only received the potassium for three days, but was still being administered the medication until it was brought to the facility staffs' attention by the surveyor. The IDON stated the expectation was for staff to follow physician orders and administer corrected doses as prescribed.

R61 was prescribed gabapentin (for nerve pain) 900 mg (3 300 mg capsules). On 5/31/16, at 11:20 a.m. a review of R61's 5/16, MAR revealed R61's noon dose of the pain medication was not initialed by the nurse as administered on 5/29 or 5/30. R61's two medication card/pill packets showed both cards had been refilled by the pharmacist on 5/27/16, with 30 pills in each packet. On 5/31/16, R61's card/pill packets indicated R61's had 33 out of 60 pills remaining and was given 27 pills during the five days.

R69's 5/16, MAR was reviewed on 5/31/16, at 11:20 a.m. Although the antipsychotic risperidone 0.5 mg was ordered daily at bedtime, that MAR revealed for four consecutive days from 5/27 to 5/30/16, R69 did not receive the medication as

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prescribed. The staff had circled the medications and wrote on the MAR on 5/29/16, "ordered." On the reverse side of the MAR a comment by a nurse dated 5/27/16, read, "Risperidone 0.5 mg 1 tab unable to locate medication, omni care pharmacy contacted. Refill available 6/1/16." No further explanations were written on the MAR.

On 5/31/16, at 2:20 p.m. a trained medication assistant (TMA)-A reported she was the person who had called the pharmacy to order the medication on Sunday, 5/29/16. TMA-A and the surveyor checked the medication cart, and TMA-A said she could not find any available risperidone for R69. TMA-A then called the pharmacy, who reported the medication had been delivered to the facility the previous day on 5/30/16. Two hours later the TMA-A explained she had checked all the medication carts and medication storage rooms on both floors of the facility and still could not find R69's missing medication.

At 2:27 p.m. IDON then verified R69 had not been administered the risperidone for four days, and she was "still looking: for the missing medication that had been delivered the previous day. The IDON stated the expectation was that staff would notify the pharmacy in advance of medication running out, and to follow up with Omnicare if medication was not received.

In a follow-up interview on 6/1/16, at 8:05 a.m. the IDON explained R69's missing risperidone pills had been found on a different floor in the building. The IDON explained the nurse managers were responsible to go through each resident's MAR monthly, and check for initials where medications may have been omitted. The nurse was then to

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F 333	Continued From page 121 follow up on any concerns. The IDON verified nurse managers had not been completing the checks. Going forward, the nurse managers would be reviewing all resident records weekly for accuracy. R42 was admitted to the facility on 12/14/15, and currently took Coumadin (blood thinner medication) daily per physician's orders for a diagnosis of Atrial Fibrillation. Medication error report dated 5/29/16, indicated that at 5:30 p.m. on 5/29/16, was discovered that her last physician's order read: Coumadin 3 mg (milligrams) PO (oral) on 5/26/16, with an INR re-check on 5/27/16. It was noted that there were no INR labs in the chart or new order for Coumadin on 5/27/16. It was also noted that there was no indication on the medication administration record (MAR) that she had received Coumadin for either 5/27/16, or 5/28/16. The report indicated the physician was called and a STAT INR lab was ordered prior to administering the required dose of Coumadin. The report also indicated the resident was monitored for the rest of the weekend for any adverse reactions to the missing doses of Coumadin. During interview with LPN-A stated after INR lab results come back the physician is called by the nurse to get the new dose of Coumadin and for the next recheck INR lab. LPN-A stated if not careful can miss a step, really important for all the steps. LPN-A stated once the order is received from the physician, the order is transcribed and a lab slip entered into the log book and faxed over. LPN-A stated Coumadin's were most often given at 5 p.m. every day, and if the results were not back by the end of the day shift, would report off	F 333		

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F 333	Continued From page 122 to next nurse coming on. LPN-A restated a dose could be missed is a step was skipped. RN-C standing nearby stated there was a break in the system and would make change. At 9:00 a.m. the interim DON stated the nurse working the evening the coumadin had been missed had only worked at the facility for a week and the nurse had thought the Coumadin had been discontinued. Interim DON stated the particular staff had been educated regarding the incident.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by:	F 425		7/11/16

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F 425	Continued From page 123 Based on observation, interview and document review, the facility failed to ensure medications were administered consistent with manufacturer's guidelines for 1 of 2 (R20) resident whose eye drop administration was observed. Findings include: During an observation of medication administration on 5/23/16, 5:22 p.m. A trained medication aide (TMA)-A was preparing to administer R20's medication. He prepared the medications, knocked on the door, and then entered R20's room. He first administered the oral medications. Then at 5:31:16 he administered Combigen (an intraocular pressure lowering agent used to treat glaucoma) 1 drop (drop) into the right eye. At 5:31 TMA-A immediately administered Dorzalamide (an ophthalmic solution used to treat glaucoma and ocular hypertension). Although the written physician orders did not specify the amount of time that should be allotted between eye drop administrations, the directions on both medication packages directs staff to wait 10 minutes between administrations of the two eye medications. Furthermore, the Federal Drug Administration (FDA) prescribing information, side effects, and uses (Drugs.com provided by the facility) directs staff to wash hands before and after using Combigen and use at least five minutes apart from any other medication that is put in the eye. The FDA guidelines also directs staff administering Dorzolomide to wash hands prior to use and to administer multiple ophthalmic medications at least 5 minutes apart. When interviewed after leaving R20's room,	F 425	1. F20 medications have been administered consistent with physicians order and manufacturers guidelines. The TMA was educated on administration of eye drops along with infection control practices with administration of medication upon notification. 2. Residents that resident at PHR who receive eye drops have the potential to be affected by this practice. The policy and procedure for medication administration and procedure for administration of eye drops was reviewed. Residents that receive eye drops Care Plans were reviewed and updated as appropriate to include manufacturer's guideline on administration of eye drops when administering multiple prescription drops. 3. Licensed Nurses and TMA's were educated on administration of medication specific to eye drops and on the policy and procedure on infection control practices during medication administration. 4. EON/designee will conduction audits on medication administration of eye drops 3 x per week x 4 weeks, then 3 x per month x 3 months. 5. DON/designee will forward all medication administration audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	

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TMA-A explained that he did not wait any amount of time between the 2 prescribed eye medications because R20 "doesn't like to wait." He further explained he did not wash his hands or don gloves prior to administration or wash his hands after because he "had to get the medication back in the medication cart." When asked why he did not wear gloves or wash his hands prior to the administration of the eye medications he explained it was not a practice the facility implemented.

The Physician Order sheet, dated May 2016, identified R20 to have a diagnosis of glaucoma.

The Sensory/Communication care plan dated 6/10/15 directed staff to administer "meds as ordered."

When interviewed on 5/24/16, at 2:37 p.m. a registered nurse interim (RN)-E stated staff was expected to use standards of practice and "go by" the manufacturer's guidelines that were on the package. She further stated, "He obviously did not follow the directions to administer eye drops effectively. " Combigen (an intraocular pressure lowering agent used to treat glaucoma) 1 drop into the right eye. At 5:31:41 he immediately administered Dorzalamide (an ophthalmic solution used to treat glaucoma and ocular hypertension).

Although the written physican orders do not specify the amount of time that should be allotted between eye drop administrations, the directions on both medication packages directs staff to wait 10 minutes between administrations of the two eye medications. Furthermore, the Federal Drug Administration (FDA) prescribing information,

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side effects, and uses (Drugs.com provided by the facility) directs staff to wash hands before and after using Combigen and use at least five minutes apart from any other medication that is put in the eye. The FDA guidelines also directs staff administering Dorzolomide to wash hands prior to use and to administer multiple ophthalmic medications at least 5 minutes apart.

When interviewed after leaving R20's room, TMA-A explained that he did not wait any amount of time between the 2 prescribed eye medications because R20 "doesn ' t like to wait. " He further explained he did not wash his hands or don gloves prior to administration or wash his hands after because he "had to get the medication back in the medication cart." When asked why he did not wear gloves or wash his hands prior to the administration of the eye medications he explained it was a practice he did not apply.

The Physician Order sheet for May 2016 identifies R20 to have a diagnosis of glaucoma.

The Sensory/Communication care plan dated 6/10/15 directs staff to administer "meds as ordered."

The Procedure for Eye Drops (to safely administer medications to the eye), effective July 2015, directs staff to wait 3-5 minutes before instilling the next eye drop.

When interviewed on 5/24/16, at 2:37 p.m. a registered nurse interim (RN)-E stated staff is expected to use standards of practice and "go by" the manufacturer's guidelines that were on the package. She further stated, "He obviously did not follow the directions to administer effectively."

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F 425	Continued From page 126 At 2:48 pm the director of nursing explained that her expectations were for staff to deliver medications to residents in the facility as they were ordered and as guidelines and standards direct. R78 RIGHT TAG? OR 431 or 431 TOO for different reasons? R78's medication administration record (MAR), narcotic book, and nursing notes were reviewed from 5/1 to 5/27/16, and the following information/inconsistency was noted: Physician's orders for R78 included Oxycodone HCL (narcotic pain medication) 5 milligrams (mg) two tablets twice daily before dressing changes and 5 mg every four hours as needed for pain rated 8-10. Orders also included Lidocaine 2% gel (numbing agent) topically to foot wounds twice daily with dressing changes, and Naproxen 500 mg twice daily (anti-inflammatory). The narcotic book revealed R78's Oxycodone was administered at a significantly greater frequency than was reflected on the MAR. In fact, the narcotic book initialed R78 was administered Oxycodone between 2-7 times daily, with 3-9 pills administered per day. The narcotic book reflected 162 pills were administered however, the MAR reflected 100. Page 55 of the narcotic record showed counts that were crossed off/changed on five occasions between 5/25 and 5/26/16, and two pills were not counted as missing. For example: Date Time Dose Amount Remaining Noted on MAR 5/26/16 5:30 a.m. 1 tab 8	F 425		

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yes			
5/26/16	9:00 (illegible)	1 tab	6
unclear			
5/26/16	8:00 p.m.	1 tab	4
yes			
5/27/16	12:00 a.m.	1 tab	3
no			
5/27/16	8:00 a.m.	1 tab	2
no			
5/27/16	9:00 a.m.	2 tabs	0
yes			

Specific examples included:

1) Page 55 of the narcotic book showed R78 was administered one tablet of Oxycodone on three occasions between 5/23 and 5/25/16, when the MAR indicated two tablets were administered prior to wound care.

2) A nursing note on 5/1/16 indicated "resident has had his wound care do [sic]. He needs a new script for Oxycodone. Call was made to on call [physician] to let them know. She did call Omnicare [pharmacy] and gave an order for 15 tablets." The narcotic book indicated "Date Received 5/1/16 Quantity Received 13" (versus 15), with no accounting for the missing two pills.

3) A nurse's note dated 5/14/16, at 1:00 p.m. indicated the resident refused wound care and was requesting Oxycodone. Although wound care was not performed, the narcotic book showed the resident was administered Oxycodone 10 mg at 8:00 a.m., no medication at 1:00 per the resident's request, and then 10 mg again at 8:00 p.m.

4) Although a nursing note on 5/21/16, at 10:30

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a.m. revealed the nurse "has been attempting to arouse resident to give him his pain medicine and do his wound care. Unable to awaken him" the narcotic book showed Oxycodone 10 mg was administered at 10:30 a.m.

5) Various orders related to twice daily dressing changes were signed off, sometimes were left blank, and sometimes were circled, but only three days included an explanation (unable to get treatment done, refused treatment, and wound clinic). Although it was unclear whether the wound treatment was completed those shifts, Oxycodone was consistently signed off as administered.

6) Documentation on the MAR indicated PRN doses of Oxycodone were also administered, however, no explanation was provided showing the resident rated his pain at 8, 9 or 10. Two days the the resident rated his pain at 7, however, the Oxycodone was administered anyway. Non-pharmacological interventions of positioning and distraction were only noted four times in the month. The efficacy of the PRN medication was only documented twice.

The interim director of nursing (IDON) was interviewed on 6/1/16, at 8:27 a.m. regarding the narcotic system in the facility. She stated, "We did call the former DON to get a statement as to what led to all of this. We told her we are looking for destruction and disposition [of narcotics]. She said she 'followed the policy' because it almost appears as if a whole log of meds is missing." The IDON explained the nurse manager and assistant DON "were the primary destroyers of meds." The IDON thought perhaps the paper trail was lost when the DON was leaving her role.

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PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 425	Continued From page 129 They had called the pharmacist who verified they did not take narcotics back, even when they had not been used. The IDON said they needed to inform the physician as to R78's pain scale ratings if it is lower, but is asking for PRN Oxycodone for pain rated at 7. When asked about issues related to documentation regarding pain and pain medications on the MAR and narcotic books the IDON stated, "We have a lot of opportunities to improve."	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		7/11/16

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F 431	Continued From page 130 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to establish a system to minimize the risk of loss and/ or diversion of narcotic medications for 1 of 2 (R100) resident reviewed for pain. Findings include: R100 was admitted to the facility on 1/14/16 status post abdominal surgery and removal of a pelvic mass related to ovarian carcinoma. A review of the narcotic log book, page 63, verified on 1/15/16, R100 had Oxycodone HCL (a controlled narcotic medication to relieve moderate to severe pain), 5 milligram tablets (mg), quantity 27 and directed staff to administer 2-3 tablets every (q) 3 hours as needed for moderate to severe pain. The log showed no tablets were removed from the medication card. Across the page from corner to corner was a line and a hand-written note, "DON office 1/18/16 and was signed by one staff. On 5/27/16, at 9:16 a.m. the interim director of nursing (IDON) explained the pharmacy sent 27(quantity) Oxycodone HCL (extended release) to the facility. Of these, none were administered	F 431	1. R100 no longer resides at the facility. 2. Residents that reside at PHR who receive controlled substances have the potential to be affected by this practice. The policy and procedure for the destruction of controlled substances was reviewed and is current. The unaccounted dispositions were self reported to OHFC with an investigation and report submitted. 3. Licensed nurses as well as the DON have been educated on the policy and procedure of the destruction of controlled substances 1 x per week x 4 weeks then 1 x per month x 3 months. 5. DON/designee will forward all controlled substance destruction audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th 2016	

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F 431	Continued From page 131	F 431		

to R100. There were no records explaining how or if they were disposed of, however the narcotic book showed they were put in the office of the director of nursing (DON) awaiting destruction. She further explained that although the DON signed narcotic page to verify she took procession, there was no follow-up regarding disposition of the narcotics.

A Proof of delivery receipt dated 1/15/16, at 9:21 a.m. and signed by staff verified R100 received 27 count of Oxycodone HCL.

During a telephone conversation on 5/31/16, at 9:20 a.m. the consultant pharmacist verified R100's Oxycodone was not sent back to the pharmacy stating their policy did not allow the return of controlled medications.

The facility's 7/15, Procedure for the Destruction of Controlled Drugs directed staff to destroy all controlled substances in the presence of two licensed nurse designated by the DON or according to state regulation. The two licensed nurse must sign on the bottom of the proof-of-use inventory page in the bound Controlled Substance Record Book.

On 5/31/16, at 9:58 a.m. the IDON stated she expected staff to follow the Board of Pharmacy Guidelines and the facility policy to dispose of narcotic medication when they are no longer being used, the procedure is to have two nurses sign the narcotic book and send to office of the DON to be destroyed or kept under a double-lock system. "I am not sure if this was being done at the time, I wasn't here." She further stated she could not verify what became of R100's 27 tablets of Oxycodone.

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		7/11/16

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F 441	Continued From page 133 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to ensure proper hand washing techniques for 1 of 1 resident (R17) whose wound dressing treatment was observed. In addition, control guidelines were not implemented during a medication administration pass for 1 of 2 residents (R20) whose eye drop administration was observed. Findings include: R17 was observed in his room on 5/25/16, at 9:31 a.m. while waiting for a dressing change. His left leg was un-bandaged and reddened scabs were toed on the front of his lower leg and ankle. A licensed practical nurse (LPN)-A walked into R17's room, donned gloves, removed R17's right stocking, and cut off the the old dressing on the resident's leg. The dressing contained reddish drainage that was wet with some detectable odor. LPN-A stated the wound physician had seen R17 the previous day and changed the treatment was now debriding (removing tissue) the wound. LPN-A dabbed at the wound with gauze, sprayed wound cleanser and dabbed with gauze, and then wiped off with a new gauze. While wearing the same soiled gloves, LPN-A began the clean part of the dressing change and squeezed ointment onto a Q-tip and applied it to the wound. Again while wearing the same soiled gloves LPN-A applied an adaptic pad and 4 x 4 pad, wrapped with gauze and cut and applied tape to hold in place. After the treatment was completed LPN-A removed the gloves, applied alcohol gel to his hands, and without washing applied clean gloves. LPN-A then dated the tape 5/25/16. LPN-A then removed his gloves and washed his hands.	F 441	1. R17 no longer resides at facility. The TMA who was responsible for the administration of the eye drop and the nurse responsible for the wound treatment have been educated. 2.Residents that reside at PHR who receive wound treatments and eye drops have the potential to be affected by this practice. The infection control policy, glove and hand washing policy and procedure have been reviewed and are current. Wound dressing and administration of eye drops policy have been reviewed and are current. 3. Licensed nurses and TMAs have been educated on sound treatment procedure. 4. DON/designee will conduct audits on hand washing, use of gloves, administration of eye drops, and wound treatments will be completed 1 x per week x 4 weeks then 1 x per month x 3 month. 5. DON/designee will forward all hand washing, use of gloves, administration of eye drops, and wound treatment audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvement. 6. Completion date: July 11th, 2016	

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F 441	Continued From page 134	F 441		

LPN-A assisted R17 to walk to his bed and lie down. As R17 walked to the bed, a Band-Aid was observed on the back of R17's left lower leg above his ankle. LPN-A reminded R17 to elevate his legs to reduce swelling. LPN-A donned new gloves, removed the Band-Aid and told R17 he would be back, as he wanted to talk to the nurse practitioner about the resident's weeping legs prior to changing the dressing of the left leg.

Following the dressing change at 9:51 a.m. LPN-A reported he thought he had changed his gloves after removing the soiled dressings, as he recalled washing his hands "a couple times."

On 5/26/16, at 11:25 a.m. RN-C stated she expected staff to remove their gloves after removing soiled wound dressings, to wash their hands, and then re-glove prior to starting clean dressing treatments. RN-C said education of staff was needed.

The interim director of nursing IDON) stated on 5/26/16, at 1:59 p.m. the nurses should have washed hands and applied gloves before beginning the treatment. Old dressings and then soiled gloves were to be removed, hands washed, and then new gloves donned before proceeding with wound treatment. The IDON the reason for the donning of gloves, washing hands and re-gloving was to minimize contamination, and staff would "need to work on that."

R20's observation of medication administration was observed on 5/23/16, at 5:22 p.m. by a trained medication aide (TMA)-A. Oral medications were prepped and then were brought with eye drops into R20's room. TMA-A

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F 441	Continued From page 135	F 441		

administered the oral medications and then immediately administered glaucoma mediations Combigen and Dorzalamide. TMA-A did not wash hands or don gloves prior to administering R20's medications.

Upon leaving the room, TMA-A explained he did not wash before or after administering the medications or don gloves because he "had to get the medication back in the medication cart." When asked why handwashing was not performed prior to the administration of the eye medications he explained it was a practice the facility did not implement.

During an interview on 5/24/16, at 2:39 p.m. an interim registered nurse (RN)-E stated she considered the lack of washing hands and gloving before and after eye drop medication administration was an infection control and staff re-training issue.

The Federal Drug Administration's prescribing information, side effects, and uses (Drugs.com, provided by the facility) directed hand washing prior to and after using Combigen and Dorzolomide.

The Procedure for Eye Drops (to safely administer medications to the eye), effective July 2015, directs staff to wash hands, donn clean gloves, wait 3-5 minutes before instilling the next eye drop, wash hands and apply new clean gloves if adminstering medication to the other eye, remove gloves and discard, wash hands.

When interviewed on 5/24/26, at 2:48 p.m. the director of nursing stated she definitely expects staff to follow the facility's policy to wash hands

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F 441	Continued From page 136 before and after eye medication and glove removal.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were properly functioning for 1 of 1 resident (R97) who was observed needing assistance from a nurse. Findings include: R97 stated in an interview on 5/23/16, at 2:29 p.m. she was receiving a wound vac treatment(mechanical intervention to promote wound healing). The resident's call light cord was clipped to a blanket on the resident's bed. Following the interview the wound vac alarm began sounding and R97 stated, "I put my call light on for a nurse to come and see why it [wound vac] is beeping." After three minutes of a continuous loud beeping the surveyor noticed the light above the door outside the room was not lit up to inform staff help was needed. R97 explained her call light did not work "most of the time," as the red button got stuck in the depressed position instead of popping back up. R97 stated, "I can't get out of bed or walk on my own. I need staffs' help, so I just wait for someone to hear it beeping or to walk by my	F 463	1. R97 call light was replaced. 2. Residents that reside at PHR have the potential to be affected by this practice. All call lights were checked to ensure they are all in working order. 3. Staff have been educated on proper functioning of call lights and what to do in the event of a malfunctioning call light. 4. Director of Maintenance/designee will perform random audits of call light functioning 5 x per week x 4 weeks then 5 x per month x 3 months. 5. Director of Maintenance/designee will forward all call light audits to the monthly QAPI committee monthly x 3 months for continued opportunities for improvement. 6. Completion date: July 11th 2016	7/11/16

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F 463	Continued From page 137 room." R97's care plan dated 5/16 indicated the resident required assistance of two staff with a mechanical lift for transferring, was at risk for falling, and had current pressure ulcers. Interventions included keeping R97's call light within reach and encouraging participation in cares. The goal was for an infection free wound that showed signs of healing. At the time of the interview with R97 two registered nurses (RN)-B and (RN)-C both verified R97's call light was not working properly and both noticed the red button on the call light was in the depressed position. A short time later RN-B stated the non-working had been replaced and was now working. RN-B and RN-C acknowledged R97 was dependent on staff for mobility and transferring, and required nursing staff to monitor and maintain proper working medical equipment. RN-B and RN-C verified all residents should have had a properly working call light at all times. During an interview on 5/24/16, at 7:39 a.m. the executive director (ED) explained, that she and housekeeping and maintenance staff went to each room to ensure call lights were in proper working order. Weekly room checks for 3/16 and 4/16, revealed R97's room had been checked on 3/29/16 and 4/4/16, and no concerns were documented. A call light policy was requested but was not received.	F 463		
F 520	483.75(o)(1) QAA	F 520		7/11/16

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F 520 SS=F	Continued From page 138 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the quality assurance (QA) committee failed to implement and reevaluate systems to identify and correct identified quality deficiencies in the facility. This had the potential to affect all residents residing in the facility. Findings include:	F 520	1. QA meets on a monthly basis and identifies quality issues and action plans are developed and reviewed. 2. The agenda for the QA meeting has been reviewed and is current. QA met on 6/21/16 utilizing agenda while discussing infection control, occurrence report, financials, CASPER report, resident concern reports, current action plans,	

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F 520	Continued From page 139 An interview was conducted on 6/1/16, at 10:45 a.m. with a registered nurse (RN)-B, the interim administrator and the interim director of nursing (IDON). The IDON stated she was aware narcotic medications were inconsistently counted between two shifts. The IDON stated she had attended one QA meeting since starting as IDON at the facility. The IDON recognized the facility needed more direct oversight, therefore the decision for her to go from consultant for the facility to IDON. RN-B stated the previous year's correction plan for narcotics not being counted consistently involved five random audits three times a week to determine if there were missing holes in the counting procedure. RN-B stated the audits were completed for an unidentified length of time and then stopped. RN-B stated the DON was to review the narcotic sheets every month. IDON stated the inconsistency with staff narcotic count was getting better but verified missing holes were still occurring with the narcotic count. IDON stated this had not been brought up at the last QA meeting she had attended. RN-B read from online pharmacy consultant reports starting from 6/2015 to the present indicating there was still a problem with missing holes on the narcotic sheets where two nurses were to verify the correct narcotic count for each resident receiving narcotics before and after each shift. The pharmacy report dated 5/17/16, indicated there were still holes with 15 holes on garden and 6 holes on east. RN-B stated this was documented in the QA minutes as "Refer to pharmacy report." RN-B stated she did not see a specific action plan in the QA minutes to rectify the problem. RN-B stated missing narcotic counts had been a reoccurring problem since identified at the previous survey and according to the monthly pharmacy reports confirmed was still a problem.	F 520	PIPs and current state POC. 3. IDT QAPI committee team members have been educated on the agenda and development of action plans. 4. DCS/designee will audit monthly QA minutes to ensure implementation and follow through has been documented and executed for action plans and PIPs. 5. Executive Director/designee will forward QAPI audits to the monthly QAPI committee monthly x 3 months for continued opportunities for improvement.	

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F 520	Continued From page 140 IDON stated the two priority issues QA was working on were skin/pressure ulcers and staff recruitment/retention with pool nursing staff utilized at the facility starting in 12/15. RN-B stated QA committee had identified multiple issues at the facility but could not address all the issues going on at the facility and had to prioritize as there were many systems lacking in the facility. RN-B stated the facility was presently only able to put systems in place and had not yet had a chance to evaluate the systems. RN-B stated the facility had not re-evaluated after the audits put in place for correction from the previous survey, documentation for the audits were unable to be provided, and there were no evaluation of the outcomes from the audits. RN-B stated the facility was aware of missing narcotics from January 2016 when medications were to be disposed after a resident discharge and had just reported the missing narcotics to the police after questioned from another surveyor during the survey process. RN-B stated the facility did not suspect drug diversion and stated the previous DON had been very meticulous with her records. RN-B stated she thought it was just a "documentation problem."	F 520		

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	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

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

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 24, 2016. At the time of this survey, Park Health and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2016**

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PARK HEALTH AND REHABILITATION CENTER	**4415 WEST 36 1/2 STREET** **SAINT LOUIS PARK, MN 55416**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Park Health and Rehab Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II (111) construction. In 1970 and addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. Because the construction height and fire protection systems allow for Type II (000) construction, the facility was surveyed as 1 building. The facility has a capacity of 81 beds with a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at	K 025		7/11/16

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	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2016**

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K 025	Continued From page 2 least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect on 43 residents. Findings include: 1. On a facility tour between the hours of 09:00 AM and 01:00 PM on May 24, 2016, observation revealed that there were penetrations in the 2nd floor smoke barrier wall between room 210 and the nursing Office. 2. On a facility tour between the hours of 09:00 AM and 01:00 PM on May 24, 2016, observation revealed that the 1st floor smoke barrier wall could not be verified due to the monolithic ceiling and a lack of access panels. This deficient practice was verified by the Director of Maintenance at the time of the inspection.	K 025	Bids obtained 7-1-16. Work to be one by due date	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency	K 144	Updated log sheets to include cool down. Completed 5-24-16	5/24/16

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K 144	Continued From page 3 generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 43 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on May 24, 2016, observation revealed that the generator cool down period was not documented separately from the load test run time. These deficient practices were verified by the Director of Maintenance at the time of the inspection.	K 144		