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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZHIN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00913

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHEL CARE CENTER**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/08/2017** (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 **141** (L18)

13.Total Certified Beds **141** (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
	141			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 02/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/20/2017 (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
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/21/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245295
March 20, 2017

Ms. Kelly Ellis, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

Dear Ms. Ellis:

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 January 31, 2017 the above facility is certified for or recommended for:

141 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 141 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 17, 2017

Ms. Kelly Ellis, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Number S5295026 & H5295122

Dear Ms. Ellis:

On January 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 22, 2016 that included an investigation of complaint number H5295122.

This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 22, 2016, effective January 31, 2017 and therefore remedies outlined in our letter to you dated January 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 17, 2017

Ms. Kelly Ellis, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Number F5295025

Dear Ms. Ellis:

On January 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 7, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2017, effective January 31, 2017 and therefore remedies outlined in our letter to you dated January 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

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
245295 Y1	A. Building B. Wing Y2	2/8/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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 F0166	Correction	ID Prefix F0174	Correction	ID Prefix F0225	Correction
Reg. # 483.10(j)(2)-(4)	Completed	Reg. # 483.10(g)(6)(7)(i)	Completed	Reg. # 483.12(a)(3)(4)(c)(1)-(4)	Completed
LSC	01/31/2017	LSC	01/31/2017	LSC	01/31/2017
ID Prefix F0226	Correction	ID Prefix F0241	Correction	ID Prefix F0253	Correction
Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed	Reg. # 483.10(a)(1)	Completed	Reg. # 483.10(i)(2)	Completed
LSC	01/31/2017	LSC	01/31/2017	LSC	01/31/2017
ID Prefix F0278	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.20(g)-(j)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	01/31/2017	LSC	01/31/2017	LSC	01/31/2017
ID Prefix F0314	Correction	ID Prefix F0318	Correction	ID Prefix F0371	Correction
Reg. # 483.25(b)(1)	Completed	Reg. # 483.25(c)(2)(3)	Completed	Reg. # 483.60(i)(1)-(3)	Completed
LSC	01/31/2017	LSC	01/31/2017	LSC	01/31/2017
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(h)(5)	Completed	Reg. #	Completed
LSC	01/31/2017	LSC	01/31/2017	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SR/KJ	03/17/2017	16022	02/08/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/22/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245295 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	2/7/2017 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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 K0361	Correction Completed 01/31/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 03/17/2017	SIGNATURE OF SURVEYOR 37008	DATE 02/07/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/5/2017	☐ 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: ZHIN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00913

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHEL CARE CENTER**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2016** (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 **141** (L18)
13.Total Certified Beds **141** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	141			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 01/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/02/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2017

Ms. Kelly Ellis, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Number S5295026 and Complaint Number H5295122

Dear Ms. Ellis:

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

On December 22, 2016, a standard survey was completed at your facility by the Minnesota Department of Health 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 December 22, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5295122, which was found to be substantiated at F225, F226, F282 and F314.

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

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

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

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 31, 2017, 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 January 31, 2017 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 March 22, 2017 (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 June 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation were also completed at the time of the standard survey. An investigation of complaint H5295122 was completed. The complaint was substantiated. Deficiencies issued at F225, F226, F282, F314	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 166		1/31/17

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

Electronically Signed | 01/20/2017

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F 166	Continued From page 1 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,	F 166		

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F 166	Continued From page 2 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that prompt efforts were made by the facility to resolve grievances for 1 of 1 resident (R88) reviewed, who expressed a grievance to facility staff. Findings include:	F 166	Immediate Corrective Action: Social Services followed up with R88 on 1.13.17 to set up a care conference related to R88 plan of care. The care conference was held on 1/18/17.	

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F 166	Continued From page 3 When interviewed on 12/19/16, at 6:45 p.m. R88 expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance and that a care conference was supposed to have been scheduled and that had not happened yet either. During an interview with R88 on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16 and no family care conference had been set up as the facility had said they would do 12/2/16. Document review of the quarterly Minimum Data Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer, anxiety, asthma and depression. Document review of the form titled; Grievance Form, dated 12/2/16, read, "Resident reported someone (nurse or nurse aide) left [R88] in [R88] wheelchair for a long time without transferring [R88] to [R88] bed. [R88] also reports they keep forgetting to give [R88] showers. Resident has stated [R88] either has or would like to call Welcov Corporate to voice [R88] concerns. The section which reads; Action taken to address Grievance: read, Reported to MDH (Minnesota Department of Health) Investigation initiated. Care Plan meeting being set up by social services with resident and [R88] family. The responsible person signature on the form was the Director of Nursing (DON) and dated 12/5/16. The administrator signed the Grievance	F 166	Resident R88 was offered a shower on 1/18/17. Actions as it Applies to Others: Staff will be re-educated related to the Grievance Policy and Procedure by 1/31/17: The Resident Grievance form has been updated and the IDT will be educated on the new Grievance form by 1/31/17. A new grievance log was developed to track all resident grievances to ensure ongoing compliance with facility policy. Social services was educated on the log on 1/13/17. The Grievance policy and procedure was reviewed on 1/17/17 and remains current. Recurrence will be prevented by: Social services will review and discuss all resident grievances daily Mon-Fri during the IDT quality conference to ensure follow-up and resolution with resident concerns. Each grievance will be reviewed until resolution has been achieved and reviewed with the resident. This will be an ongoing facility practice. The Correction will be monitored by: Administrator/Designee	

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F 166	Continued From page 4 form 12/5/16. Document review of the policy titled Grievance/Concern, Revision date: July 2015, indicated a written report of investigation and recommended action will be completed and returned to Administrator/Social Service Director within 72 hours. A meeting with the resident/representative will occur to review the findings and actions taken and/or those that will be taken. If they are not satisfied with the results, other actions will be developed as needed. During an interview with the DON and Administrator on 12/22/16, at 8:40 a.m. verified they were not aware of the follow up and did not have any other documentation for investigation of the 12/2/16, concern. During an interview on 12/22/16, at 11:30 a.m. with the current social worker (SW)-A who had been working as a temporary fill in social worker since 12/11/16, verified no knowledge of the resident or family anticipating a meeting to discuss concerns. SW-A was not aware to set up a meeting with the resident or family. Furthermore, SW-A verified not seeing the Grievance/Concern for R88 and not being informed of the follow up required. SW-A verified the facility did not follow up with a care conference for the resident and family to discuss care concerns but SW-A would follow up immediately.	F 166		
F 174 SS=E	483.10(g)(6)(7)(i) RIGHT TO TELEPHONE ACCESS WITH PRIVACY (g)(6) The resident has the right to have reasonable access to the use of a telephone,	F 174		1/31/17

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F 174	Continued From page 5 including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. (g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure 7 of 47 residents (R82, R12, R55, R91, R43, R115 and R167) on the 3rd floor had reasonable access to privacy when using the telephone for making/receiving personal phone calls. Findings include: Document review of R82's most recent Minimum Data Set (MDS), dated 9/17/16, revealed severe cognitive impairment. During an observation on 12/19/16, at 6:45 p.m. R82 was being assisted by licensed practical nurse (LPN)-B to make a phone call from the nursing desk. R82 could be overheard speaking on the phone by those at the desk and in the common area near the phone. LPN-B reported not being aware of any other phone for residents to use. Document review of R12's most recent MDS, dated 9/13/16, revealed R12 had severe cognitive impairment and required extensive assistance	F 174	Immediate Corrective Action: "A grievance form was completed on behalf of residents R82, R12, R55, R 91, R43, R115, R167 regarding access to a private phone." Actions as it Applies to Others: All cordless phones will be examined to ensure the phones are in working condition. Cordless phones will be located behind the nurses' station and a sign-out log will be implemented. Nursing staff will be educated on the new sign-out sheet for the use of the phone and the need to provide residents with privacy while using the phone by January 31, 2017. Recurrence will be prevented by: Resident interviews will be conducted 3x weekly for 90 days on each unit to ensure residents are provided privacy while using the phone. The interview results will be	

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F 174	Continued From page 6 from staff to complete all activities of daily living including locomotion on and off the unit. During an observation on 12/19/16, at 6:56 p.m., nursing assistant (NA)-E assisted R12 to make a phone call at the nursing desk. R12 was seated right next to R82, who was still using the phone. NA-E reported there was a cordless phone but that another resident might be using it. Document review of R55's most recent (MDS), dated 10/10/16, revealed R55 was cognitively intact and did not transfer from bed or other surfaces. When interviewed on 12/20/16 at 10:32 a.m., R55 reported there was a cordless phone on the unit, but that it was often not able to be located or in use by another resident. R55 reported missed calls and that people were unable to contact [R55] via phone anymore. R55 reported there was no good system for phone use. Document review of R91's most recent MDS, dated 11/24/16, revealed moderate cognitive impairment. When interviewed on 12/20/16, at 11:53 a.m., R91 reported not being able to make a private phone call and there was sometimes 3-4 people waiting to use the phone on the unit. Document review of R43's most recent MDS, dated 11/16/16, revealed moderate cognitive impairment. During an observation on 12/20/16, at 12:37 p.m., LPN-A informed R43 about a phone call and then directed R43 to a phone at the nursing desk. R43	F 174	shared with the IDT at the monthly QAPI for recommendations on the need to continue or discontinue audits. The Correction will be monitored by: Social Services and/or designee	

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F 174	Continued From page 7 stood at the nursing desk to make the phone call. LPN-A did not offer another, more private area, to make a phone call to R43. During an observation on 12/20/16, at 3:50 p.m. R115 made a phone call from the nursing desk. During an observation on 12/22/16, at 10:15 a.m. R167 made a phone call from the phone at the nursing desk. There was background noise as other residents and staff were in the area and R167 was observed to use hand to cover the ear not being used by the phone. R167 reported prefering to make a private phone call. R167 pointed to a cordless phone on a table in the dining room and reported it did not work when attempted to use it on multiple occasions. A policy on telephone privacy was requested but not provided.	F 174		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225		1/31/17

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F 225	Continued From page 8 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 225		

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F 225	Continued From page 9 investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 document review and interview, the facility failed to ensure that all alleged violations of mistreatment, neglect and abuse are thoroughly investigated, reported to the administrator immediately and reported immediately to the state agency for 1 of 3 residents (R55) reviewed for incidents. Findings include: R55 reported on 9/7/16, at 8:11 p.m. that the nurse threatened to take away the oxygen and the incident was not reported to the administrator or state agency until 9/12/16, at 12:00 p.m. R55 was assessed as cognitively intact according to the minimum data set (MDS) annual review 10/10/16, and diagnoses from the MDS included coronary artery disease, heart failure and hypertension. R55 had a physician order for 3 liters of oxygen via nasal cannula (nc) continuously due to chronic obstructive pulmonary disease. According to the document titled, Progress notes, written by registered nurse (RN)-I dated 9/7/16, at 8:11 p.m. read; Writer notified of incident and	F 225	Immediate Corrective Action: RN-I was counseled on 1/16/17 for failing to ensure the timely notification of alleged abuse per facility policy. Corrective Action as it Applies to Others: The policy and procedure “Abuse Prevention Plan” was reviewed and remains current. Nursing staff will be re-educated on the policy with respect to immediate reporting, and the initiation of internal investigations for any allegation of abuse. Recurrence will be prevented by: All Alleged incidents of abuse, mistreatment, neglect, or injuries of unknown origin and/or misappropriation of resident property will be audited to ensure timely reporting, immediate initiation of the internal investigation process and to ensure that witness interviews have been conducted per facility policy and procedure. Audits will be completed for 90 days, and audit results will be shared with the IDT during the monthly QAPI meeting for input on the need to continue or	

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F 225	Continued From page 10 spoke with the patient who verbalized, "the nurse cannot take away my oxygen, where is the doctors order". Pt was upset and speaking very loud. Writer apologized for any misunderstanding and ensured pt that the oxygen would remain in [R55] room and we will do anything we can to ensure [R55] is comfortable and safe. Pt further verbalized that [R55] did not want the nurse in [R55] room "ever again". Writer continued to comfort pt and assured pt that this nurse would stay out of [R55] room. Pt thanked writer and verbalized being comfortable and without pain or SOB [shortness of breath]. O2 [oxygen] sats [saturation] 94% on 3 L [liters] O2 via nc. Writer spoke with nurse and ensured that [RN-J] would remain out of the patients room the remainder of the shift and we would follow up tomorrow. Nurse verbalized understanding. No further issues noted. According to the document titled, Progress notes, written by RN-J dated 9/7/16, at 6:42 p.m. read, Behavior: Patient threatened writer and NAR [nursing assistant registered] after walking to patients room to verify the oxygen compressor was for another resident. Patient was aggressive (threw a cup at me) and abusive using all the words in the book. Writer told the incident to other nurses working on the unit. Will monitor residents behavior. According to the document titled, Internal Investigation Form, on 9/12/16, at 12:00 p.m. the mental health practitioner reported to the administrator and director of nursing that R55 expressed the incident on 9/7/16 where the charge nurse pointing finger in res face and threatening to take O2 from the resident.	F 225	discontinue auditing. The Correction will be monitored by: Administrator and/or designee.	

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F 225	Continued From page 11 During an interview on 12/22/16, at 8:40 a.m. with the administrator and director of nursing (DON) verified RN-I failed to follow the facility policy to report abuse immediately to the administrator and the state agency on 9/7/16, at 8:00 p.m. failed to immediately start an internal investigation and failed to inform them of the situation until the mental health practitioner reported the abuse on 9/12/16, at 12:00 p.m. Furthermore, no written statement was obtained or interview conducted from the NAR reported as a witness. Document review of the facility policy revision dated, Nov 2016, and titled, Abuse Prevention Plan, read; "The administrator is ultimately in charge of the Abuse Prohibition Plan and must be informed of all alleged or substantiated incidents of abuse, neglect, or maltreatment immediately. In the case of the administrator being unavailable, the designee will be notified in this timeframe. The State Agency must be notified immediately". Furthermore, for Investigation the document directed the facility staff would complete an incident report by a licensed staff immediately following the incident. The unit manager/night supervisor would implement immediate changes to keep the resident safe, with follow up implementation reviewed to make sure that they are appropriate for the resident and condition of resident. Under the Internal Reporting the policy directed; 1. All incidents that are suspicious in nature will be investigated by the internal process. 2. Upon receipt of the report, the DNS or designee on duty will begin investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document such findings. 3. That documentation will include the following; Identify the resident, identify the caregiver, Time, date	F 225		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12 and location of suspected maltreatment, Nature and extent of the suspected maltreatment, Any other information believed helpful in investigating the suspected maltreatment. Facility will accomplish this by completing the accident/Incident report or issue and concern form. Analyze the occurrences to determine what changes are needed is any to policy and procedures to prevent further occurrences.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226		1/31/17

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F 226	Continued From page 13 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow the policy to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were reported to the state agency and thoroughly investigated for 1 of 3 residents (R55) reviewed for incidents. Findings include: Document review of the facility policy revision dated, Nov 2016, and titled, Abuse Prevention Plan,read, "The administrator is ultimately in charge of the Abuse Prohibition Plan and must be informed of all alleged or substantiated incidents of abuse, neglect, or maltreatment immediately. In the case of the administrator being unavailable, the designee will be notified in this timeframe. The State Agency must be notified immediately". Furthermore, for Investigation the document directed the facility staff would complete an incident report by a licensed staff immediately following the incident. The unit manager/night supervisor would implement immediate changes to keep the resident safe, with follow up implementation reviewed to make sure that they are appropriate for the resident and condition of resident. Under the Internal Reporting the policy directed; 1. All incidents that are suspicious in nature will be investigated by the internal process. 2. Upon receipt of the report, the DNS or	F 226	Immediate Corrective Action: RN-I was counseled on 1/16/17 for failing to ensure the timely notification of alleged abuse per facility policy. Corrective Action as it Applies to Others: The policy and procedure “Abuse Prevention Plan” was reviewed and remains current. Nursing staff will be re-educated on the policy with respect to immediate reporting, and the initiation of internal investigations for any allegation of abuse. Recurrence will be prevented by: All Alleged incidents of abuse, mistreatment, neglect, or injuries of unknown origin and/or misappropriation of resident property will be audited to ensure timely reporting, immediate initiation of the internal investigation process and to ensure that witness interviews have been conducted per facility policy and procedure. Audits will be completed for 90 days, and audit results will be shared with the IDT during the monthly QAPI meeting for input on the need to continue or discontinue auditing. The Correction will be monitored by:	

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F 226	Continued From page 14 designee on duty will begin investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document such findings. 3. That documentation will include the following; Identify the resident, identify the caregiver, Time, date and location of suspected maltreatment, Nature and extent of the suspected maltreatment, Any other information believed helpful in investigating the suspected maltreatment. Facility will accomplish this by completing the A\accident/Incident report or issue and concern form. Analyze the occurrences to determine what changes are needed is any to policy and procedures to prevent further occurrences. R55 reported on 9/7/16, at 8:11 p.m. that the nurse threatened to take away the oxygen and the incident was not reported to the administrator or state agency until 9/12/16, at 12:00 p.m. R55 was assessed as cognitively intact according to the minimum data set (MDS) annual review 10/10/16, and diagnoses from the MDS included coronary artery disease, heart failure and hypertension. R55 had a physician order for 3 liters of oxygen via nasal cannula (nc) continuously due to chronic obstructive pulmonary disease. According to the document titled, Progress notes, written by registered nurse (RN)-I dated 9/7/16, at 8:11 p.m. read; Writer notified of incident and spoke with the patient who verbalized, "the nurse cannot take away my oxygen, where is the doctors order". Pt was upset and speaking very loud. Writer apologized for any misunderstanding and ensured pt that the oxygen would remain in	F 226	Administrator and/or designee.	

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F 226	Continued From page 15	F 226		

[R55] room and we will do anything we can to ensure [R55] is comfortable and safe. Pt further verbalized that [R55] did not want the nurse in [R55] room "ever again". Writer continued to comfort pt and assured pt that this nurse would stay out of [R55] room. Pt thanked writer and verbalized being comfortable and without pain or SOB [shortness of breath]. O2 [oxygen] sats [saturation] 94% on 3 L [liters] O2 via nc. Writer spoke with nurse and ensured that [RN-J] would remain out of the patients room the remainder of the shift and we would follow up tomorrow. Nurse verbalized understanding. No further issues noted.

According to the document titled, Progress notes, written by RN-J dated 9/7/16, at 6:42 p.m. read, Behavior: Patient threatened writer and NAR [nursing assistant registered] after walking to patients room to verify the oxygen compressor was for another resident. Patient was aggressive (threw a cup at me) and abusive using all the words in the book. Writer told the incident to other nurses working on the unit. Will monitor residents behavior.

According to the document titled, Internal Investigation Form, on 9/12/16, at 12:00 p.m. the mental health practitioner reported to the administrator and director of nursing that R55 expressed the incident on 9/7/16 where the charge nurse pointing finger in res face and threatening to take O2 from the resident.

During an interview on 12/22/16, at 8:40 a.m. with the administrator and director of nursing (DON) verified RN-I failed to follow the facility policy to report abuse immediately to the administrator and the state agency on 9/7/16, at 8:00 p.m. failed to

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F 226	Continued From page 16 immediately start an internal investigation and failed to inform them of the situation until the mental health practitioner reported the abuse on 9/12/16, at 12:00 p.m.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure a dignified environment for 2 of 4 residents (R140, R160) reviewed for dignity by not providing furniture to accommodate residents of all sizes, and by not ensuring resident privacy from the window view in the shower room. Findings include: Document review of the electronic medical record (eMR) revealed R140 was admitted to the facility on 7/21/2016. R140 was assessed as cognitively intact during the quarterly minimum data set (MDS) assessment 11/10/16. R140 weighed 486 pounds on 12/21/16, as documented in the electronic medical record. During an observation on 12/20/16, at 10:05 a.m. R140 was laying in bed. R140's room furnishings lacked seating other than the resident's bed and wheelchair. R140 said the facility did not have a chair to sit in yet, and did not think a wheelchair	F 241	Immediate Corrective Action: A grievance form was completed for residents R140 and R160 about accommodating seating and privacy. Corrective Action as it applies to others: Blinds were provided for all shower rooms and installed on January 31, 2017. A chair will be ordered for R140 by January 31, 2017. Other residents will be interviewed to determine if additional concerns exist regarding the availability of accommodating seating based on resident weight/size. Additional furniture will be obtained by January 31, 2017 to accommodate other residents with similar concerns. The policy and procedure for Resident Rights and Dignity for all Nursing Procedures was reviewed and remains	1/31/17

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F 241	Continued From page 17 counted as a normal chair. Since being admitted in July, R140 did not feel able to get in and out of the wheelchair safely, explaining "I can't get my legs underneath me to get out of the wheelchair on my own." R140 said that the last time two staff tried to assist with the transfer out of the wheelchair, R140 fell back down onto the wheelchair, hit backside of body on the chair, and snapped head back after falling on the wheelchair. R140 said it took six facility staff to get R140 back up again. During an observation on 12/21/16, at 8:24 a.m. R140 was eating breakfast in bed. When asked whether R140 preferred eating in bed, R140 explained eating in bed because the main dining area on the unit did not have chairs to accommodate weight/size. When asked whether R140 was interested in spending time in the common area, R140 stated, "I want to get out there! But they aren't even bothering to get me a real chair out there. They tell me I can sit in my wheelchair, but I don't want the wheelchair! I want a real chair." At 2:03 p.m. R140 described speaking about wanting a bigger chair to "anyone and everyone," but that eventually staff said they couldn't find one. During an interview on 12/21/16, at 2:39 p.m. the occupational therapist (OT) explained the facility was unable to find a wheelchair to accommodate R140 that was covered by insurance. Furthermore, the OT verified the facility currently did not have a chair that was wide enough to accommodate R140. During showers, R160 was not provided dignity of privacy from view of the window to the outside property.	F 241	current. Nursing staff will be re-educated on the policy by January 31, 2017. Recurrence will be prevented by: Resident interviews will be conducted on each unit 3x a week for 90 days to ensure residents needs are met in a manner that promotes dignity about accommodating seating and privacy. Audit results will be shared with the IDT during the monthly QAPI meeting for recommendations on the need to continue or discontinue audits. The Correction will be monitored by: Administrator and/or designee	

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F 241	Continued From page 18	F 241		

Document review of the quarterly MDS, dated 12/6/16, indicated R160 was cognitively intact.

During an interview on 12/20/2016, at 11:57 a.m. R160 described a courtyard outside that residents used as a smoking area. R160 said from this courtyard, you can look up at the window in the fourth floor shower room and see the silhouette of the person in the shower room. R160 said it was possible to tell if the person in the shower room was male or female, and mentioned asking staff for curtains multiple times. R160 said staff tried to reassure that it was not possible to see anything from the courtyard outside, even though R160 insisted on seeing the body outlines from the courtyard.

During an observation on 12/21/16, at 1:39 p.m. the fourth floor shower room was observed to have two shower stalls separated by a curtain. The shower stall farthest from the doorway was against the outside wall of the building. This wall had a large window with frosted glass that overlooked the courtyard below. The window started approximated 1.5 feet up from the floor, was approximately 4 feet wide, and approximately 5 feet tall. The window lacked a curtain.

During an observation from the courtyard on 12/21/2016, at 2:34 p.m. the fourth floor shower room window was visible from the courtyard below. From the courtyard, a registered nurse (RN-A) looked up at the window while someone stood in the shower room. The figure of the person in the shower room was visible. RN-A verified it was possible to see the outline of the person while looking up from the courtyard. RN-A confirmed staff would contact maintenance to

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F 241	Continued From page 19 hang a curtain in the window for privacy.	F 241		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on document review, interview, and observation, the facility failed to provide a comfortable odor free room environment for resident (R55) and failed to ensure the environment was maintained in a safe and comfortable manner for 9 of 10 residents (R160, R140, R91, R166, R103, R50, R157, R155, R159) reviewed for environmental concerns. Findings include: R55's most recent Minimum Data Set (MDS), dated 10/10/16, revealed R55 was cognitively intact and did not transfer from bed or other surfaces. On 12/20/2016, at 9:41 a.m., R55 reported the urine smell in the room gave R55 headaches. R55 reported was unable to leave the room and the condition of the room made R55 "very depressed", adding "I got no choice. Anyone else can come in and leave." R55's room was noted to have a strong foul urine odor. R55 also expressed concern as was vulnerable to infection and did not feel the condition of the room was sanitary, based on observations of odors. On 12/22/16, at 9:53 a.m., R55's room again had a strong foul urine odor. On 12/22/16, at 9:35 a.m. during environmental tour with the maintenance director (MD) and environmental director (ED), the following	F 253	Immediate corrective action: Handrails in 300 hallway will be refinished and endcap by the laundry room was replaced on 12/7/16. The edges to the countertop near nurses' station will be replaced with a cleanable edge guard. Fans and Vents were all cleaned and placed on a regular cleaning schedule on 1/3/17. Wheelchair armrests will be replaced for residents 4, 7, 40 and 41 by 1/3/17. Missing tile in laundry room will be replaced by 1/3/17. Duct work in laundry room loose insulation was removed on 12/7/16. Action as it applies to others: The Preventative Maintenance Program was reviewed and remains current. Administrator will follow the schedule below to assure Program is followed and facility is kept in clean order and good repair.	1/31/17

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F 253	Continued From page 20 concerns were noted. R55's room was observed to have a strong foul urine odor. R55 stated can't you smell it, gets headaches from the smell, but had no headache now. Registered nurse (RN)-F indicated had been working with staff to clean the room. RN-F stated R105 will pull catheter out, staff can't help it, and that contributed to the smell. RN-F stated staff will strip bed and clean the room three to four times a day. ED confirmed the room was a concern with staff cleaning it three to four times a day. On 12/22/16, at 9:35 a.m. during environmental tour with the maintenance director (MD) and environmental director (ED), the following concerns were noted and verified: On 12/20/16, at 12:31 p.m. R160's room was observed to have two pillowcases covering R160's pillow. R160 asked staff to double up pillow cases because there often were stains on the linens. The pillowcase had light brown stains on the inside pillowcase. On 12/20/16, at 10:57 a.m. R140 was observed to have a stain on a sheet being used for a window covering to keep the breeze out. On 12/20/16, at 1:10 p.m. R91's room was observed with small areas of paint peeling on the wall near the bed. In addition, the wood molding had several chips in it. On 12/19/16, at 4:46 p.m. R166's room door was observed with several jagged pieces along the inside edge. The window sill nails were jutting out from the bottom side of the sill. The head of bed was next to the window sill, which was falling apart on the underside. The bathroom door had	F 253	All resident wheelchairs arms were inspected and will be replaced if needed. Recurrence will be prevented by: Walking rounds by the Maintenance Director and Administrator or designee will be completed 3x weekly x 90 days to review facility cleanliness and maintenance needs. Administrator will report results to facility QAPI committee for input on the need to increase, decrease or discontinue the frequency of rounds. The correction will be monitored by: Administrator/Maintenance Director	

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F 253	Continued From page 21 broken off and the Formica had jagged edges. On 12/19/16, at 5:47 p.m. R103's room window blinds were observed with holes measuring approximately 4 inches by 4 inches on the right and left sides of each. The room was cluttered with a bin of clothes near the window and R103 stated they needed name labels and should go to the wash. On 12/19/16, at 5:08 p.m. R103 stated his room was cold. On 12/20/16, at 11:45 a.m. R50's room door was observed to not close, the inside handle was loose and there were several holes midway up the hallway wall near the bed. On 12/20/16, at 11:59 a.m. R160's bathroom was observed to have a dirty air vent. R160 stated she placed a towel on the shower room chair to sit on it, a towel on the floor for her feet, and would not allow her body to touch the dirty surfaces. On 12/20/16, at 8:49 a.m. R157 stated room was cold next to the window by the bed and there was a draft. On 12/20/16, at 12:35 p.m. R155 stated at night the room was cold and thought the window leaked a bit. On 12/19/16, at 4:30 p.m. R159 stated the room was cool, told staff, but it still was cold. When interviewed on 12/22/16, at 10:58 a.m. MD stated would go into a room for maintenance checks when it was vacant and checked blinds, doors, and all other things. MD stated every nurse	F 253		

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F 253	Continued From page 22 station had a maintenance request book where staff entered maintenance requests. Additional maintenance staff checked the request books daily at 1:00 p.m. Document review of an undated policy titled, Room Readiness Check List Housekeeping check list directed: "wipe down bed frame, head and foot boards, mattress, side rails... Sweep and mop floor checking corners, edges, and behind the door... Record any maintenance issues. Document reivew of Audit Tool - Environmental directed: "Directions: Random weekly audits for environmental to ensure facility maintains a sanitary, orderly, and comfortable interior" No maintenance policy was provided for preventative maintenance routines. During an interview on 12/22/16, at 1:49 p.m, a family member of R159 (F)-Q, noted cracks in the floor near the window and marks on the floor. F-Q reported the floor had been that way since R159 was admitted, and F-Q did not think it was in satisfactory condition.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278		1/31/17

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F 278	Continued From page 23 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to accurately assess 1 of 3 residents (R140) reviewed for activities of daily living. Findings include: Document review of the minimum data set (MDS) assessment, dated 11/10/16, revealed that the facility coded R140 as needing limited assistance while eating. According to the MDS, "limited assistance" is defined as the resident being highly involved in the activity, but staff providing guided maneuvering of limbs, or other non-weight bearing assistance. This was a decline compared to the previous MDS assessment, dated	F 278	Immediate Corrective Action: The MDS dated 11/10/16 for resident R140 was amended on January 31, 2017. Corrective Action as it applies to others: MDS staff will be educated on the review and verification of supporting ADL documentation prior to coding the MDS January 31, 2017. Recurrence will be prevented by: MDS audit reviews will be conducted randomly 3x/week for ADL accuracy. Audits will continue for 90 days and be reviewed with the IDT, monthly, during the QAPI meeting to determine the need to	

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F 278	Continued From page 24 10/27/16, when staff assessed R140 to need only supervision to eat. According to the MDS, "supervision" is defined as staff oversight, encouraging, or cueing. Document review of progress notes dated 11/6/16-11/12/16, around the timeframe of the 11/10/16 assessment, did not reveal any documentation about a change in R140's capability to feed self. Document rview of R140's current nutrition care plan, created 8/17/16, revealed that R140 was able to eat independently after set-up. Document review of Weekly Medicare meeting notes from 11/15/16, revealed R140 was on a regular diet and able to feed self independently. During observation and interview on 12/21/2016, at 8:24 a.m. R140 ate breakfast alone in bed. When asked about needing help to eat, R140 confirmed no help was needed, as R140 was able to eat independently. During an interview on 12/21/16, at 1:53 p.m. a nursing assistant (NA- B) familiar with R140's care said R140 did not need help to eat. NA-B explained that staff brought meals in to R140's room and left them there, because R140 did not need help setting up the meal tray, or reaching eating utensils. During an interview on 21/21/16, at 1:22 p.m. a registered nurse (RN-E) said that in order to code R140 as needing limited assistance, staff must have helped in some way by providing non-weight bearing support during meals. When asked where nursing staff documented examples of this	F 278	continue or discontinue auditing. The Correction will be monitored by: DON and/or Designee	

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F 278	Continued From page 25 support in the medical record, RN-E reviewed progress notes, but was unable to find any notes associated with changes or declines in eating. According to RN-E, notes showed only that R140 was stable with no changes. During an interview on 12/22/16, at 11:45 a.m. RN-D was unable to find documentation of what staff were doing when they provided limited assistance during meals. RN-D said guiding limbs was an example of limited assistance, but there was no documentation of such in the medical record. RN-D called nursing staff on R140's floor to ask for anyone familiar with the resident's care. Over the phone, staff confirmed R140 did not need help eating.	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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, and observation, the facility failed to provide a restorative nursing program as ordered by the physician and as directed by the plan of care, for 1 of 1 resident (R88) in the sample identified for passive range of motion (PROM) to upper extremities and for 1 of 3 residents, R64, reviewed for pressure ulcers and personal hygiene.	F 282	Immediate Corrective Action: Resident R88 was reassessed by therapy on 12/22/16 and PROM recommendations were re-implemented. (RN)-B and (NA)-A were counseled for failing to provide resident R88 with PROM in accordance with the written plan of care.	1/31/17

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F 282	Continued From page 26 Findings include: R88 did not receive PROM to upper extremities, daily, as ordered by the physician and as directed by the plan of care. When interviewed on 12/19/16, at 6:45 p.m. R88 expressed serious concern due to being a quadriplegic and unable to move any part of the body or extremities except for slight movement of the head, staff were not consistently providing passive range of motion to the upper extremities as ordered by the physician. R88 referred to the process of "stretching me out" that was not occurring daily even when R88 would remind the staff the PROM to the upper extremities was to be completed daily. Document review of the plan of care with a date initiated of 10/20/16, and Revision on 12/13/16, read, Restorative: Passive Range of Motion to bilateral shoulders, elbows, wrists, fingers, daily up to 10 reps. (repetitions) (Gently stretch before PROM (passive range of motion) Resident is very capable of communicating [R88] needs. Document review of the form titled; Restorative Nursing Program, dated 10/13/16, by the Occupational Therapist directed PROM to the right and left upper extremities to be completed one time a day for 10 repetitions. The registered nurse (RN) signed the form on 10/26/16, and four nursing assistants (NA) signed the form on 11/7/16, indicating training occurred.. Document review of the policy titled; Care Planning, dated revision August 2016, read, Individual, resident-centered care planning be	F 282	Nursing assistants (NA) - C and (NA) - D were counseled for failing to provide cares in accordance with the written plan of care for resident R64. The care plan and care card for resident R64 were reviewed and updated on 12/22/16. Corrective Action as it applies to others: Other residents with therapy recommendations for restorative nursing services will be reviewed to ensure the recommendations remain current and are being provided in accordance with individualized care plans. Residents at risk for pressure ulcer development, per their current skin assessment, will have care plan reviews completed to ensure interventions are implemented to prevent or heal current pressure ulcers. The resident care guides will be updated to reflect current care planned interventions. Residents who are dependent with toileting will have care plan reviews completed to ensure interventions are implemented to meet the resident's needs based on the current bladder assessment. The resident care guides will be updated to reflect current care planned interventions. Policy and Procedure titled "Care Planning" was reviewed and remains current. Staff will be re-educated on the policy by January 31, 2017.	

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F 282	Continued From page 27 initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. When interviewed on 12/22/16, at 12:41 p.m. the occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremities. Document review of the form titled Treatment Sheet, and indicated 12/1/16 - 12/31/16, revealed PROM was not documented as occurred until 12/16/16, 12/17/16, 12/18/16 12/19/16 and 12/20/16. No other dates for December 2016 were documented. When interviewed on 12/22/16, at 9:45 a.m. R88 stated the PROM did not occur on 12/21/16. When interviewed on 12/22/16, at 10:00 a.m. RN-B verified the PROM was not completed for R88 on 12/22/16 and RN-B was not sure who was responsible for completing the PROM and would need to check if therapies or nursing were to complete the PROM. When interviewed on 12/22/16, at 12:55 p.m. NA-A who worked with R88 on 12/21/16, verified PROM was not completed on 12/21/16 for R88. NA-A verified the PROM was to be coordinated with the nurse which had not occurred 12/21/16. When interviewed on 12/22/16, at 10:20 a.m., RN-A verified the nursing staff were to complete	F 282	Recurrence will be prevented by: Visual audits will be conducted 3x/week on each unit to ensure staff remain complaint with providing care consistent with the resident's individualized plan of care for toileting, repositioning and restorative nursing services. Audits will continue for 90 days and be reviewed during the monthly QAPI meeting to determine the need to continue or discontinue auditing. The Correction will be monitored by: DON and/or Designee	

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F 282	Continued From page 28	F 282		

and document the restorative nursing PROM for R88 daily. Furthermore, RN-A verified nursing did not document daily services for PROM for [R88] on the December treatment record.

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R64's hygiene, skin and activity of daily living care plan, last revised 8/24/16, directed staff " Staff of 2 to turn and reposition every 2 hours in bed and wheelchair. Staff ensure comfort and assist to maintain position with pillows in bed. Use draw sheet to prevent friction/shearing with repositioning."

R64's care plan, last revised 8/24/16, directed staff "I am total assistance with 2 staff for toileting needs. Staff will transfer me to bed, and change my brief, and provide pericares and adjust clothing as needed."

The care guide, undated,directed staff "Q1 hr [every 1 hour] reposition."

The care guide, undated, further directed staff "Incontinent of B&B [Bowel and Bladder] Check and Change q [every] 2 hours."

During continuous observation on 12/21/16 from 7:32 a.m. to 12:44 p.m., R64 was noted to be sitting in R64's wheelchair for 4 continuous hours without being repositioned, offloaded or checked for incontinence. At 7:32 a.m., two nursing assistants, (NA)-C and (NA)-D were observed to change R64's incontinence brief and clean her perineal area as they provided R64 with morning cares and then transferred R64 from a bed into a wheelchair. At 8:19 a.m., R64 was wheeled to

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F 282	Continued From page 29 the dining room. At 8:48 a.m., the nurse (RN)-G, provided care to R64 briefly in the hallway near the dining room. At 9:04 a.m. R64 ate breakfast with assistance from staff. At 9:32 a.m. R64 was finished eating breakfast, yet remained at the table. At 9:54 a.m., the activity assistant, (AA)-A, wheeled R64 onto the elevator and to the dining room for a church service. R64 remained in the dining room until 10:42 a.m. when AA-A wheeled R64 back onto the elevator and to the unit. At 10:45 a.m. RN-G provided cares near the medication cart until 10:47 a.m. R64 then sat in her wheelchair near the dining room table until 12:13 p.m. when NA-C wheeled R64 from the table to her room. NA-C and NA-D reported they had repositioned, offloaded or checked R64 for incontinence since they assisted her with morning cares at 7:32 a.m. At 12:19 p.m. NA-C and NA-D used a mechanical lift to transfer R64 from a wheelchair to a bed. NA-C and NA-D then adjusted R64's pants, removed R64's used incontinence brief, cleaned the perineal area and applied cream to R64's bottom, applied a new brief and adjusted R64's pants. R64 was wheeled back to the dining room at 12:44 p.m. When interviewed on 12/21/16, at 1:49 p.m., RN-G reported she did not assist R64 with repositioning, offloading or checking R64 for incontinence that day. RN-G reported R64 should be repositioned or offloaded and checked for incontinence every 2 hours. At this time, the nurse manager, RN-F, reported staff should reposition R64 every 1 hour and check for incontinence every 2 hours and change incontinence brief as needed according to the care guide.	F 282		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		1/31/17

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F 312 SS=D	Continued From page 30 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure necessary personal hygiene was maintained and activities of daily living preferences were provided for 1 of 3 residents reviewed for activities of daily living, R64. Findings include: Document review of R64's most recent Minimum Data Set [MDS], dated 11/23/16, had long and short term memory problems and severely impaired cognitive skills for daily decision making. The MDS, dated 11/23/16, revealed R64 required extensive assistance from 2 or more staff for personal hygiene and bed mobility and was totally dependent on assistance from 2 or more staff for toileting and transfers. When interviewed on 12/20/16 at 10:40 a.m., a family member of R64's (F)-A, reported concerns R64 was not provided with the help needed with hygiene cares because R64 had smelled of "poop" when F-A visited and F-A had spoke to the facility several times about those concerns. On 12/22/16 at 11:32 a.m., F-A, reported visiting recently and R64 had an odor of bowel movement/urine and that was a frequent occurrence. During continuous observation on 12/21/16 from	F 312	Immediate Corrective Action: Nursing assistants (NA) - C and (NA) - D were counseled for failing to provide cares in accordance with the written plan of care for resident R64. Corrective Action as it applies to others: The policy and procedure for Nursing Care Standards was reviewed on 1/17/17 and remains current. Nursing staff will be re-educated on the policy by January 31, 2017. Residents who are dependent with toileting will have care plan reviews completed to ensure interventions are implemented to meet the resident's needs based on their current bladder assessment. The resident care guides will be updated to reflect current care planned interventions. Recurrence will be prevented by: Visual audits will be conducted 3x/week on each unit to ensure staff remain complaint with providing care consistent with the resident's individualized plan of care for toileting. Audits will continue for 90 days and be reviewed during the monthly QAPI meeting to determine the need to continue or discontinue auditing	

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F 312	Continued From page 31 7:32 a.m. to 12:44 p.m., R64 was noted to be sitting in a wheelchair for 4 continuous hours without being checked for incontinence of bowel or bladder or provided perineal cares. At 7:32 a.m., two nursing assistants, (NA)-C and (NA)-D were observed to change R64's incontinence brief and clean the perineal area as they provided R64 with morning cares. At 8:19 a.m., R64 was wheeled to the dining room. At 8:48 a.m., the nurse (RN)-G, provided care to R64 briefly in the hallway near the dining room. At 9:04 a.m. R64 ate breakfast with assistance from staff. At 9:32 a.m. R64 was finished eating breakfast, yet remained at the table. At 9:54 a.m., the activity assistant, (AA)-A, wheeled R64 onto the elevator and to the dining room for a church service. R64 remained in the dining room until 10:42 a.m. when AA-A wheeled R64 back onto the elevator and to the unit. At 10:45 a.m. RN-G provided cares near the medication cart until 10:47 a.m. R64 then sat in the wheelchair near the dining room table until 12:13 p.m. when NA-C wheeled R64 from the table to R64's room. NA-C and NA-D reported they had not checked R64 for incontinence or provided perineal cares for R64 since they assisted R64 with morning cares at 7:32 a.m. At 12:19 p.m. NA-C and NA-D used a mechanical lift to transfer R64 from a wheelchair to the bed. NA-C and NA-D then adjusted R64's pants, removed R64's used incontinence brief, cleaned R64's perineal area and applied cream to R64's bottom, applied a new brief and adjusted R64's pants. R64 was wheeled back to the dining room at 12:44 p.m. On 12/21/16 at 1:49 p.m. RN-G reported she did not assist R64 with checking or changing her incontinence brief that day. RN-G reported R64 should be checked for incontinence every 2 hours	F 312	The Correction will be monitored by: DON and/or Designee	

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and staff should change R64's incontinence brief and apply cream to R64's bottom if there was a bowel movement. At this time, the nurse manager, RN-F, verified staff should check R64 every 2 hours and change R64's incontinence brief as needed.

The care area assessment, dated 3/15/16, noted " Resident triggered for urinary CAA related to always incontinent of B & B and total assist with all toileting needs. Resident is always incontinent of bladder. She has no control present and has no pattern of incontinence. She receives total assistance of 2 staff for toileting needs. Staff will change brief, provide pericare and adjust clothing after each incontinence. Staff will check her every two hours and change as needed. EPC cream is applied after each incontinent episode."

R64's care plan, last revised 8/24/16, directed staff " Bowel & Bladder Function: I am incontinent of bowel and bladder. I do wear incontinent briefs and need total assist with pericares. I usually have a bowel movement everyday. I do not use the bathroom. I am at risk for constipation d/t [due to] limited mobility." The interventions included "I am total assistance with 2 staff for toileting needs. Staff will transfer me to bed, and change my brief, and provide pericares and adjust clothing as needed." The hygiene, skin and activity of daily living care plan, last revised 8/24/16, directed staff " My routine is to get up for meals and sit in the dayroom and people-watch or enjoy the music or activity for a while before I lay down between meals. I like to nap between meals as I get tired from sitting too long in my wheelchair."

The care guide, undated, further directed staff "Incontinent of B&B [Bowel and Bladder] Check

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F 312	Continued From page 33 and Change q [every] 2 hours."	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure repositioning was provided to prevent pressure ulcer development for 1 of 3 residents, R64, reviewed for pressure ulcers. Findings include: Document review of R64's most recent Minimum Data Set [MDS], dated 11/23/16, had long and short term memory problems and severely impaired cognitive skills for daily decision making. The MDS, dated 11/23/16, revealed R64 required extensive assistance from 2 or more staff for personal hygiene and bed mobility and was totally	F 314	Immediate Corrective Action: Nursing assistants (NA) - C and (NA) - D were counseled for failing to provide cares in accordance with the written plan of care for resident R64. The care plan and care card for resident R64 were reviewed and updated on 12/22/16. Corrective Action as it applies to others: Residents at risk for pressure ulcer development, per their current skin assessment, will have care plan reviews completed to ensure interventions are	1/31/17

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F 314	Continued From page 34 dependent on assistance from 2 or more staff for toileting and transfers. During continuous observation on 12/21/16, from 7:32 a.m. to 12:44 p.m., R64 was noted to be sitting in R64's wheelchair for 4 continuous hours without being repositioned or offloaded. At 7:32 a.m., two nursing assistants, (NA)-C and (NA)-D were observed to provide morning cares and then transferred R64 into a wheelchair. At 8:19 a.m., R64 was wheeled to the dining room. At 8:48 a.m., the nurse (RN)-G, provided care to R64 briefly in the hallway near the dining room. At 9:04 a.m. R64 ate breakfast with assistance from staff. At 9:32 a.m. R64 was finished eating breakfast, yet remained at the table. At 9:54 a.m., the activity assistant, (AA)-A, wheeled R64 onto the elevator and to the dining room for a church service. R64 remained in the dining room until 10:42 a.m. when AA-A wheeled R64 back onto the elevator and to the unit. At 10:45 a.m. RN-G provided cares near the medication cart until 10:47 a.m. R64 then sat in R64's wheelchair near the dining room table until 12:13 p.m. when NA-C wheeled R64 from the table to R64's room. NA-C and NA-D reported they had repositioned or offloaded R64 since they assisted R64 with morning cares at 7:32 a.m. At 12:19 p.m. NA-C and NA-D used a mechanical lift to transfer R64 from R64's wheelchair to bed. R64 was wheeled back to the dining room at 12:44 p.m. When interviewed on 12/21/16, at 1:49 p.m. RN-G verified did not assist R64 with repositioning or offloading that day. RN-G reported R64 should be repositioned or offloaded every 2 hours. The nurse manager, RN-F, verified staff should reposition R64 every 1 hours according to the care guide.	F 314	implemented to prevent or heal current pressure ulcers. The resident care guides will be updated to reflect current care planned interventions. The Skin Program policy and procedure was reviewed and remains current. Nursing staff will be educated on the policy by January 31, 2017. Recurrence will be prevented by: Visual audits will be conducted 3x/week on each unit to ensure staff remain complaint with providing care consistent with the resident's individualized plan of care for repositioning and pressure ulcer prevention. Audits will continue for 90 days and be reviewed during the monthly QAPI meeting to determine the need to continue or discontinue auditing. The Correction will be monitored by: DON and/or designee	

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F 314	Continued From page 35 Document review of the care area assessment (CAA), dated 3/15/16, revealed "Resident triggered for pressure ulcers related to presence of stage II, total assist with all mobility, incontinence of B & B. Resident dx include end stages of dementia, DB, HTN. Some risk factors include decreased activity and mobility, decreased sensation d/t dx [due to diagnosis] of diabetes, B&B [bowel and bladder] incontinence. The interventions include turning and repositioning q2hrs [every in bed and w/c, barrier cream to buttocks and periarea, pressure reduction mattress, abductor pillow between knees, palm protectors, foam boots. [R64] skin is intact at this time." Document review of R64's hygiene, skin and activity of daily living care plan, last revised 8/24/16, directed staff " I was admitted with a stage 2 coccyx ulcer and pink areas on my buttocks which have resolved. I also have a hx of right heel ulcer and blisters on my left arm and hand. Per Braden Assessment recently completed, I am at a high risk for developing pressure ulcers d/t [due to] these risk factors; friction and shearing, contractures, decreased mobility and activity, incontinent of bowel and bladder, and dx [diagnosis of diabetes. I recently have pressure ulcer wound stage II on my left fingers (3rd,4th, 5th) possibly from friction d/t contracture. Interventions included: "Staff of 2 to turn and reposition every 2 hours in bed and wheelchair. Staff ensure comfort and assist to maintain position with pillows in bed. Use draw sheet to prevent friction/shearing with repositioning." Document review of the undated care guide,	F 314		

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F 314	Continued From page 36 directed staff "Q1 hr [every 1 hour] reposition." Document review of the Skin Program policy, last revised 9/2016, directed staff "To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds."	F 314		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a nursing restorative service as physician ordered and as directed by the plan of care, for 1 of 1 resident (R88) in the sample identified for passive range of motion (PROM) to upper extremities. Findings include: R88 did not receive PROM to upper extremeties, daily, as ordered by the physician and as directed by the plan of care.	F 318	Immediate Corrective Action: Resident R88 was reassessed by therapy on 12/22/16 and PROM recommendations were re-implemented. (RN)-B and (NA)-A were counseled for failing to provide resident R88 with PROM per the written plan of care. Corrective Action as it applies to others: Residents with therapy recommendations for restorative nursing services will be	1/31/17

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F 318	Continued From page 37 When interviewed on 12/19/16, at 6:45 p.m. R88 expressed serious concern due to being a quadriplegic and unable to move any part of the body or extremities except for slight movement of the head, staff were not consistently providing passive range of motion to the upper extremities as ordered by the physician. R88 referred to the process of "stretching me out" that was not occurring daily. Document review of the initial Minimum Data Set (MDS) dated 11/4/16, indicated R88 as cognitively intact. The physician orders dated 11/17/16, read, Restorative, bilateral U/E (upper extremity) ROM daily ROM 5-10 reps ea.(each). Document review of the plan of care with a date initiated of 10/20/16 and Revision on 12/13/16, read, Restorative: Passive Range of Motion to bilateral shoulders, elbows, wrists, fingers, daily up to 10 reps. (repetitions) (Gently stretch before PROM (passive range of motion) Resident is very capable of communicating [R88] needs. Document review of the form titled; Restorative Nursing Program, dated 10/13/16, by the Occupational Therapist (OT) directed passive ROM to the right and left upper extremities to be completed one time a day for 10 repetitions. The registered nurse (RN) signed the form on 10/26/16, and four nursing assistants (NA) signed the form on 11/7/16. When interviewed on 12/22/16, at 12:41 p.m. the OT verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16,	F 318	reviewed to ensure the recommendations remain current and are being provided in accordance with individualized care plans. The policy and procedure Restorative Nursing Services was reviewed on 1/17/17 and remains current. Recurrence will be prevented by: Visual audits will be conducted 3x/week on each unit to ensure staff remain complaint with providing care consistent with the resident's individualized plan of care for restorative nursing services. Additionally, documentation audits will be conducted to ensure restorative services are documented when completed. Audits will continue for 90 days and be reviewed during the monthly QAPI meeting to determine the need to continue or discontinue auditing. The Correction will be monitored by: DON and/or designee	

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F 318	Continued From page 38 when the nursing education was completed regarding PROM to R88's upper extremeties. Document review of the form titled Treatment Sheet, indicated 12/1/16 - 12/31/16, revealed PROM was not documented as occurred until 12/16/16, 12/17/16, 12/18/16 12/19/16 and 12/20/16. When interviewed on 12/22/16, at 9:45 a.m. R88 stated the PROM did not occur on 12/21/16. When interviewed on 12/22/16, at 10:00 a.m. RN-B verified the PROM was not completed for R88 on 12/21/16, and RN-B was not sure who was responsible to complete the PROM and would need to check if therapies or nursing were to complete the PROM. When interviewed on 12/22/16, at 12:55 p.m. NA-A who worked with R88 on 12/21/16, verified PROM was not completed on 12/21/16 for R88. NA-A verified the PROM was to be coordinated with the nurse which had not occurred 12/21/16. When interviewed on 12/22/16, at 10:20 a.m., RN-A verified the nursing staff were to complete and document the restorative nursing PROM for R88 daily. Furthermore, RN-A verified nursing did not document daily services for PROM for [R88] on the December treatment record.	F 318		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		1/31/17

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F 371	Continued From page 39 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized proper hand hygiene during meal service to reduce the risk of food borne illness for all residents who ate in the first floor dining room, and the facility failed to ensure proper hand hygiene during meal preparation, which had the potential to affect all residents who eat in the facility. Findings include: During an observation on 12/19/16, at 5:50 p.m. a dietary aide (DA-A) brought food and beverages to residents in the first floor dining room. Between bringing food and beverages out of the kitchen, DA-A washed hands in the kitchen sink, then	F 371	Immediate Corrective Action: Immediate hand hygiene re-education was provided to DA-A, C-B, and C-A. Corrective Action as it applies to others: The policy and procedure for Handwashing/Hygiene was reviewed and remains current. Dietary staff will be re-educated to the policy and procedure related to appropriate handwashing/hand hygiene and will complete a handwashing competency. Recurrence will be prevented by: Random weekly visual handwashing	

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F 371	Continued From page 40 used clean hands to shut off the water before pulling a paper towel from the dispenser to dry hands. After drying hands, DA-A brought a plate of food out to a resident in the dining room. When asked about whether the facility provided hand hygiene training, DA-A said handwashing seemed pretty common knowledge, but thought that the facility explained handwashing in the training before new employees start to work in the facility. During an observation on 12/19/16, at 5:56 p.m. a cook (C-B) dished up food on plates in the first floor dining room. Between plates, C-B washed hands in the kitchen sink, then used clean hands to shut off the water before pulling a paper towel from the dispenser to dry hands. C-B donned gloves and served up two plates of food. After removing the gloves, C-B washed hands in the kitchen sink for approximately five seconds, then shut off the water with bare hands before pulling a paper towel to dry hands. During an observation on 12/22/16, at 10:12 a.m. C-A made gravy for an upcoming meal service. C-A washed hands in the kitchen sink for approximately six seconds, then shut off the water with bare hands before pulling a paper towel from the dispenser to dry. C-A proceeded to touch the handle of a pot while melting butter on the stovetop, then donned gloves to cut onion on a cutting board. After cutting, C-A removed gloves and used bare hands to lift the lid of the garbage can next to the stove to dispose of the gloves and onion waste. C-A then washed hands in the kitchen sink for approximately five seconds, before returning to the pot on the stovetop. When interviewed on 12/22/16, at 10:39 a.m., the director of dietary services verified that new staff	F 371	audits will be conducted 3x/week for 90 days. Audit results will be reviewed monthly with the IDT during the QAPI meeting for recommendations on the need to continue or discontinue audits. The Correction will be monitored by: Dietary Manager and/or designee.	

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F 371	Continued From page 41 received handwashing training when they start the job, and explained staff also received monthly in-services that covered handwashing, among other things. The director of dietary services confirmed that staff should leave the water running while they dry their hands, then shut off the water using a paper towel. Document review of the facility policy titled; Handwashing/Hygiene, revised August 2014, revealed "Employees must wash their hands for at least twenty (20) seconds."	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441		1/31/17

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F 441	Continued From page 42 facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their	F 441		

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F 441	Continued From page 43 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were maintained for 2 of 2 residents (R83, R86) observed for activities of daily living. Findings include: During observations on 12/19/16, the following was observed during the initial tour on the second floor ventilator care unit: On 12/19/16, at 1:15 p.m. observed nursing assistant (NA)-Z leaving R83's room with gloves on holding two trash bags walking down the hallway toward R86's room and placed the bags by R86's door and entered R86's room with the same gloves on. NA-Z took the gloves off while in R86's room and came out of that room at 1:17 p.m. On 12/19/16, at 1:23 p.m. NA-Z acknowledged came from R83's room, walking in the hallway with gloves on and holding two trash bags and entered R86's room after placing the trash bags by R86's door. Removed gloves while in R86's room. During an interview on 12/21/16, at 2:20 p.m. registered nurse (RN)-C. stated the facility expectation was that all staff should remove gloves when finished from one resident's room to another and after doing cares to prevent contamination. RN-C added, Staff should not wear gloves in the hallway unless actively cleaning up bodily fluids.	F 441	Immediate Corrective Action: (NA) – Z received immediate re-education regarding glove use and hand hygiene. Corrective Action as it applies to others: The policies Glove Use and Handwashing were reviewed and remain current. Staff will be re-educated on the policies by January 31, 2017. Recurrence will be prevented by: Glove use and handy hygiene audits will be conducted 3x/week for 90 days to ensure staff remain complaint with policy and procedures. Audit results will be shared with the IDT during the monthly QAPI meeting to determine the need to continue or discontinue audits. The Corrective Action will be monitored by: DON and/or designee	

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F 441	Continued From page 44 Document review of the facility policy and procedure titled, GLOVE USE, with revision date; May 2014, indicated, "6. When resident care complete, gather soiled items in linen bag or waste container and contain. Remove gloves, WASH HANDS, take soiled bagged items to appropriate soiled room. Once placed, WASH HANDS again." Document review of the facility policy and procedure titled, HANDWASHING/HYGIENE with revision date; August 2014, stated, "5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); h. Before and after assisting a resident with personal care (e.g., oral care, bathing); After removing gloves or aprons".	F 441		
F 465 SS=E	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 465	Immediate corrective action:	1/31/17

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F 465	Continued From page 45 review,the facility failed to ensure 3 of 4 floors (2nd, 3rd and 4th) carpet was maintained, cleaned and free of odor for residents who resided on and/or visited the floors. Findings include: On 12/22/16, at 9:35 a.m. during environmental tour with the maintenance director (MD) and environmental director (ED), the following concerns were noted and verified. The carpet on 2nd, 3rd and 4th floors were observed to be worn, torn and soiled. The third floor carpet was most noticeably observed to have a strong, urine-like odor permeating throughout the unit and a large round stain observed near the shower room door. On 12/19/16, at 4:46 p.m. the carpet outside R166's room had a musty urine-like odor. When interviewed on 10/22/16, at 10:58 a.m. MD stated every nurse station had a maintenance request book where staff entered maintenance requests. Additional maintenance staff checked the request books daily at 1:00 p.m. Document reivew of Audit Tool - Environmental directed: "Directions: Random weekly audits for environmental to ensure facility maintains a sanitary, orderly, and comfortable interior." No maintenance policy was provided for preventative maintenance routines.	F 465	Facility immediately started cleaning carpets on 2nd, 3rd, and 4th floors. Action as it applies to others: Carpet seams have been glued down with edges cut down. Carpet stains have been attempted to be removed. Recurrence will be prevented by: Corporate is in final stages of negotiations with owner of building to complete a renovation project that will commence in 2017. Preventative maintenance program will be put into place to address concerns with flooring as soon as they are noted. Maintenance was educated on 1/31/17 completing and documenting routine maintenance rounds and needing repairs when identified. Negative Results will be reviewed at QAPI. The correction will be monitored by: Maintenance director and/or designee	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2017

Ms. Kelly Ellis, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, Minnesota 55102

RE: Project Number F5295025

Dear Ms. Ellis:

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

On January 5, 2017, a standard survey was completed at your facility by the Minnesota Department of Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious life safety code (LSC) deficiency in your facility 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. 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 OF PUBLIC SAFETY CONTACT

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

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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 February 14, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 April 5, 2017 (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 July 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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 ax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	**420 MARSHALL AVENUE** **SAINT PAUL, MN 55102**

(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 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. At the time of this survey, Bethel Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/20/2017

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
	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2017**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethel Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 141 beds and had a census of 96 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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BETHEL CARE CENTER	**420 MARSHALL AVENUE** **SAINT PAUL, MN 55102**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 361 SS=D	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This STANDARD is not met as evidenced by: Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/5/2017, based on observation and interview revealed that the following include: A penetration was found for a PVC drain pipe running from 2nd floor to 3rd floor for had not been fire stopped. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 361	Immediate Corrective Action: PVC drain pipe running from 2nd floor to 3rd floor was repaired with a fire barrier on 1/6/17. Corrective Action as it applies to others: Maintenance director verified no other fire barriers had breaches in them. Recurrence will be prevented by: Maintenance director ensure that when he is repairing they are not breaching fire barrier or ensuring the fire barrier is restored. Contractors in buildings will have frequent checks to ensure they have sealed fire barriers before completion of their projects. The Correction will be monitored by: Maintenance Director and/or Designee	1/31/17

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2017

Ms. Kelly Ellis, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5295026 and Complaint Number H5295122

Dear Ms. Ellis:

The above facility was surveyed on December 19, 2016 through December 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5295122, which was found to be substantiated at Minnesota Statute 626.557 Subd. 4a (St - 2 - 1995), Minnesota Rule 4658.0405 Subp. 3 (St - 2 - 0565) and Minnesota Rule 4658.0525 subp. 3 (St - 2 - 0900). At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us**.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: _____ B. WING _____	C 12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/19/16, 12/20/16, 12/21/16 & 12/22/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition complaint investigation was also completed at the time of the recertification survey. An investigation of complaint H5295122 was completed. The complaint was substantiated. Correction orders issued at State Statute 626.557 Subd. 4a (tag 1995), State Licensing Rule 4658.0405 Subp. 3 (tag 0565) State Licensing Rule 4658.0525 subp. 3 (tag 0900). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the	2 000		

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2 000	Continued From page 2 findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 380	MN Rule 4658.0200 Subp. 2 Policies Concerning Residents; Telephones Subp. 2. Telephones. A nursing home must provide at least one non-coin-operated telephone which is accessible to residents at all times in case of emergency. A resident must have access to a telephone at a convenient location within the building for personal use. A nursing home may charge the resident for actual long distance charges that the resident incurs. This MN Requirement is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure 7 of 47 residents (R82, R12, R55, R91, R43, R115 and R167) on the 3rd floor had reasonable access to privacy when using the telephone for making/receiving personal phone calls. Findings include:	2 380	Corrected	1/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 380	Continued From page 3 Document review of R82's most recent Minimum Data Set (MDS), dated 9/17/16, revealed severe cognitive impairment. During an observation on 12/19/16, at 6:45 p.m. R82 was being assisted by licensed practical nurse (LPN)-B to make a phone call from the nursing desk. R82 could be overheard speaking on the phone by those at the desk and in the common area near the phone. LPN-B reported not being aware of any other phone for residents to use. Document review of R12's most recent MDS, dated 9/13/16, revealed R12 had severe cognitive impairment and required extensive assistance from staff to complete all activities of daily living including locomotion on and off the unit. During an observation on 12/19/16, at 6:56 p.m., nursing assistant (NA)-E assisted R12 to make a phone call at the nursing desk. R12 was seated right next to R82, who was still using the phone. NA-E reported there was a cordless phone but that another resident might be using it. Document review of R55's most recent (MDS), dated 10/10/16, revealed R55 was cognitively intact and did not transfer from bed or other surfaces. When interviewed on 12/20/16 at 10:32 a.m., R55 reported there was a cordless phone on the unit, but that it was often not able to be located or in use by another resident. R55 reported missed calls and that people were unable to contact [R55] via phone anymore. R55 reported there was no good system for phone use. Document review of R91's most recent MDS,	2 380		

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2 380	Continued From page 4 dated 11/24/16, revealed moderate cognitive impairment. When interviewed on 12/20/16, at 11:53 a.m., R91 reported not being able to make a private phone call and there was sometimes 3-4 people waiting to use the phone on the unit. Document review of R43's most recent MDS, dated 11/16/16, revealed moderate cognitive impairment. During an observation on 12/20/16, at 12:37 p.m., LPN-A informed R43 about a phone call and then directed R43 to a phone at the nursing desk. R43 stood at the nursing desk to make the phone call. LPN-A did not offer another, more private area, to make a phone call to R43. During an observation on 12/20/16, at 3:50 p.m. R115 made a phone call from the nursing desk. During an observation on 12/22/16, at 10:15 a.m. R167 made a phone call from the phone at the nursing desk. There was background noise as other residents and staff were in the area and R167 was observed to use hand to cover the ear not being used by the phone. R167 reported prefering to make a private phone call. R167 pointed to a cordless phone on a table in the dining room and reported it did not work when attempted to use it on multiple occasions. A policy on telephone privacy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The	2 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 380	Continued From page 5 administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rights for privacy when using the telephone are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 380		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, and observation, the facility failed to provide a restorative nursing program as ordered by the physician and as directed by the plan of care, for 1 of 1 resident (R88) in the sample identified for passive range of motion (PROM) to upper extremities and for 1 of 3 residents, R64, reviewed for pressure ulcers and personal hygiene. Findings include: R88 did not receive PROM to upper extremities, daily, as ordered by the physician and as directed	2 565	Corrected	1/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 6 by the plan of care. When interviewed on 12/19/16, at 6:45 p.m. R88 expressed serious concern due to being a quadriplegic and unable to move any part of the body or extremities except for slight movement of the head, staff were not consistently providing passive range of motion to the upper extremities as ordered by the physician. R88 referred to the process of "stretching me out" that was not occurring daily even when R88 would remind the staff the PROM to the upper extremities was to be completed daily. Document review of the plan of care with a date initiated of 10/20/16, and Revision on 12/13/16, read, Restorative: Passive Range of Motion to bilateral shoulders, elbows, wrists, fingers, daily up to 10 reps. (repetitions) (Gently stretch before PROM (passive range of motion) Resident is very capable of communicating [R88] needs. Document review of the form titled; Restorative Nursing Program, dated 10/13/16, by the Occupational Therapist directed PROM to the right and left upper extremities to be completed one time a day for 10 repetitions. The registered nurse (RN) signed the form on 10/26/16, and four nursing assistants (NA) signed the form on 11/7/16, indicating training occurred.. Document review of the policy titled; Care Planning, dated revision August 2016, read, Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. When interviewed on 12/22/16, at 12:41 p.m. the	2 565		

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2 565	Continued From page 7 occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremities. Document review of the form titled Treatment Sheet, and indicated 12/1/16 - 12/31/16, revealed PROM was not documented as occurred until 12/16/16, 12/17/16, 12/18/16 12/19/16 and 12/20/16. No other dates for December 2016 were documented. When interviewed on 12/22/16, at 9:45 a.m. R88 stated the PROM did not occur on 12/21/16. When interviewed on 12/22/16, at 10:00 a.m. RN-B verified the PROM was not completed for R88 on 12/22/16 and RN-B was not sure who was responsible for completing the PROM and would need to check if therapies or nursing were to complete the PROM. When interviewed on 12/22/16, at 12:55 p.m. NA-A who worked with R88 on 12/21/16, verified PROM was not completed on 12/21/16 for R88. NA-A verified the PROM was to be coordinated with the nurse which had not occurred 12/21/16. When interviewed on 12/22/16, at 10:20 a.m., RN-A verified the nursing staff were to complete and document the restorative nursing PROM for R88 daily. Furthermore, RN-A verified nursing did not document daily services for PROM for [R88] on the December treatment record. Document review of R64's plan of care was not followed for pressure ulcers and personal	2 565		

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2 565	Continued From page 8	2 565		

hygiene.

R64's hygiene, skin and activity of daily living care plan, last revised 8/24/16, directed staff " Staff of 2 to turn and reposition every 2 hours in bed and wheelchair. Staff ensure comfort and assist to maintain position with pillows in bed. Use draw sheet to prevent friction/shearing with repositioning."

R64's care plan, last revised 8/24/16, directed staff "I am total assistance with 2 staff for toileting needs. Staff will transfer me to bed, and change my brief, and provide pericares and adjust clothing as needed."

The care guide, undated,directed staff "Q1 hr [every 1 hour] reposition."

The care guide, undated, further directed staff "Incontinent of B&B [Bowel and Bladder] Check and Change q [every] 2 hours."

During continuous observation on 12/21/16 from 7:32 a.m. to 12:44 p.m., R64 was noted to be sitting in R64's wheelchair for 4 continuous hours without being repositioned, offloaded or checked for incontinence. At 7:32 a.m., two nursing assistants, (NA)-C and (NA)-D were observed to change R64's incontinence brief and clean her perineal area as they provided R64 with morning cares and then transferred R64 from a bed into a wheelchair. At 8:19 a.m., R64 was wheeled to the dining room. At 8:48 a.m., the nurse (RN)-G, provided care to R64 briefly in the hallway near the dining room. At 9:04 a.m. R64 ate breakfast with assistance from staff. At 9:32 a.m. R64 was finished eating breakfast, yet remained at the table. At 9:54 a.m., the activity assistant, (AA)-A, wheeled R64 onto the elevator and to the dining

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2 565	Continued From page 9	2 565		

room for a church service. R64 remained in the dining room until 10:42 a.m. when AA-A wheeled R64 back onto the elevator and to the unit. At 10:45 a.m. RN-G provided cares near the medication cart until 10:47 a.m. R64 then sat in her wheelchair near the dining room table until 12:13 p.m. when NA-C wheeled R64 from the table to her room. NA-C and NA-D reported they had repositioned, offloaded or checked R64 for incontinence since they assisted her with morning cares at 7:32 a.m. At 12:19 p.m. NA-C and NA-D used a mechanical lift to transfer R64 from a wheelchair to a bed. NA-C and NA-D then adjusted R64's pants, removed R64's used incontinence brief, cleaned the perineal area and applied cream to R64's bottom, applied a new brief and adjusted R64's pants. R64 was wheeled back to the dining room at 12:44 p.m.

When interviewed on 12/21/16, at 1:49 p.m., RN-G reported she did not assist R64 with repositioning, offloading or checking R64 for incontinence that day. RN-G reported R64 should be repositioned or offloaded and checked for incontinence every 2 hours. At this time, the nurse manager, RN-F, reported staff should reposition R64 every 1 hour and check for incontinence every 2 hours and change incontinence brief as needed according to the care guide.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan interventions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan interventions. The quality assessment and assurance committee could perform random

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2 565	Continued From page 10 audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of	2 840		1/31/17

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2 840	Continued From page 11 the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure necessary personal hygiene was maintained and activities of daily living preferences were provided for 1 of 3 residents reviewed for activities of daily living, R64. Findings include: Document review of R64's most recent Minimum Data Set [MDS], dated 11/23/16, had long and short term memory problems and severely impaired cognitive skills for daily decision making. The MDS, dated 11/23/16, revealed R64 required extensive assistance from 2 or more staff for personal hygiene and bed mobility and was totally dependent on assistance from 2 or more staff for toileting and transfers. When interviewed on 12/20/16 at 10:40 a.m., a family member of R64's (F)-A, reported concerns R64 was not provided with the help needed with hygiene cares because R64 had smelled of "poop" when F-A visited and F-A had spoke to the facility several times about those concerns. On 12/22/16 at 11:32 a.m., F-A, reported visiting	2 840	Corrected	

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2 840	Continued From page 12 recently and R64 had an odor of bowel movement/urine and that was a frequent occurrence. During continuous observation on 12/21/16 from 7:32 a.m. to 12:44 p.m., R64 was noted to be sitting in her wheelchair for 4 continuous hours without being checked for incontinence of bowel or bladder or provided perineal cares. At 7:32 a.m., two nursing assistants, (NA)-C and (NA)-D were observed to change R64's incontinence brief and clean the perineal area as they provided R64 with morning cares. At 8:19 a.m., R64 was wheeled to the dining room. At 8:48 a.m., the nurse (RN)-G, provided care to R64 briefly in the hallway near the dining room. At 9:04 a.m. R64 ate breakfast with assistance from staff. At 9:32 a.m. R64 was finished eating breakfast, yet remained at the table. At 9:54 a.m., the activity assistant, (AA)-A, wheeled R64 onto the elevator and to the dining room for a church service. R64 remained in the dining room until 10:42 a.m. when AA-A wheeled R64 back onto the elevator and to the unit. At 10:45 a.m. RN-G provided cares near the medication cart until 10:47 a.m. R64 then sat in the wheelchair near the dining room table until 12:13 p.m. when NA-C wheeled R64 from the table to R64's room. NA-C and NA-D reported they had not checked R64 for incontinence or provided perineal cares for R64 since they assisted R64 with morning cares at 7:32 a.m. At 12:19 p.m. NA-C and NA-D used a mechanical lift to transfer R64 from a wheelchair to the bed. NA-C and NA-D then adjusted R64's pants, removed R64's used incontinence brief, cleaned R64's perineal area and applied cream to R64's bottom, applied a new brief and adjusted R64's pants. R64 was wheeled back to the dining room at 12:44 p.m.	2 840		

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2 840	Continued From page 13 On 12/21/16 at 1:49 p.m. RN-G reported she did not assist R64 with checking or changing her incontinence brief that day. RN-G reported R64 should be checked for incontinence every 2 hours and staff should change R64's incontinence brief and apply cream to R64's bottom if there was a bowel movement. At this time, the nurse manager, RN-F, verified staff should check R64 every 2 hours and change R64's incontinence brief as needed. The care area assessment, dated 3/15/16, noted " Resident triggered for urinary CAA related to always incontinent of B & B and total assist with all toileting needs. Resident is always incontinent of bladder. She has no control present and has no pattern of incontinence. She receives total assistance of 2 staff for toileting needs. Staff will change brief, provide pericare and adjust clothing after each incontinence. Staff will check her every two hours and change as needed. EPC cream is applied after each incontinent episode." R64's care plan, last revised 8/24/16, directed staff " Bowel & Bladder Function: I am incontinent of bowel and bladder. I do wear incontinent briefs and need total assist with pericares. I usually have a bowel movement everyday. I do not use the bathroom. I am at risk for constipation d/t [due to] limited mobility." The interventions included "I am total assistance with 2 staff for toileting needs. Staff will transfer me to bed, and change my brief, and provide pericares and adjust clothing as needed." The hygiene, skin and activity of daily living care plan, last revised 8/24/16, directed staff " My routine is to get up for meals and sit in the dayroom and people-watch or enjoy the music or activity for a while before I lay down between meals. I like to nap between meals as I get tired from sitting too long in my wheelchair."	2 840		

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2 840	Continued From page 14 The care guide, undated, further directed staff "Incontinent of B&B [Bowel and Bladder] Check and Change q [every] 2 hours." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for incontinence check and change to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 895	Corrected	1/31/17

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2 895	Continued From page 15 facility failed to provide a nursing restorative service as physician ordered and as directed by the plan of care, for 1 of 1 resident (R88) in the sample identified for passive range of motion (PROM) to upper extremities. Findings include: R88 did not receive PROM to upper extremeties, daily, as ordered by the physician and as directed by the plan of care. When interviewed on 12/19/16, at 6:45 p.m. R88 expressed serious concern due to being a quadriplegic and unable to move any part of the body or extremities except for slight movement of the head, staff were not consistently providing passive range of motion to the upper extremities as ordered by the physician. R88 referred to the process of "stretching me out" that was not occurring daily. Document review of the initial Minimum Data Set (MDS) dated 11/4/16, indicated R88 as cognitively intact. The physician orders dated 11/17/16, read, Restorative, bilateral U/E (upper extremity) ROM daily ROM 5-10 reps ea.(each). Document review of the plan of care with a date initiated of 10/20/16 and Revision on 12/13/16, read, Restorative: Passive Range of Motion to bilateral shoulders, elbows, wrists, fingers, daily up to 10 reps. (repetitions) (Gently stretch before PROM (passive range of motion) Resident is very capable of communicating [R88] needs. Document review of the form titled; Restorative Nursing Program, dated 10/13/16, by the Occupational Therapist (OT) directed passive ROM to the right and left upper extremities to be	2 895		

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2 895	Continued From page 16	2 895		

completed one time a day for 10 repetitions. The registered nurse (RN) signed the form on 10/26/16, and four nursing assistants (NA) signed the form on 11/7/16.

When interviewed on 12/22/16, at 12:41 p.m. the OT verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremeties.

Document review of the form titled Treatment Sheet, indicated 12/1/16 - 12/31/16, revealed PROM was not documented as occurred until 12/16/16, 12/17/16, 12/18/16 12/19/16 and 12/20/16.

When interviewed on 12/22/16, at 9:45 a.m. R88 stated the PROM did not occur on 12/21/16.

When interviewed on 12/22/16, at 10:00 a.m. RN-B verified the PROM was not completed for R88 on 12/21/16, and RN-B was not sure who was responsible to complete the PROM and would need to check if therapies or nursing were to complete the PROM.

When interviewed on 12/22/16, at 12:55 p.m. NA-A who worked with R88 on 12/21/16, verified PROM was not completed on 12/21/16 for R88. NA-A verified the PROM was to be coordinated with the nurse which had not occurred 12/21/16.

When interviewed on 12/22/16, at 10:20 a.m., RN-A verified the nursing staff were to complete and document the restorative nursing PROM for R88 daily. Furthermore, RN-A verified nursing did not document daily services for PROM for [R88]

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2 895	Continued From page 17 on the December treatment record. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for contractures to assure they are receiving the necessary treatment/services to prevent contractures. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for contracture development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		1/31/17

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2 900	Continued From page 18 Based on document review, observation, and interview, the facility failed to ensure repositioning was provided to prevent pressure ulcer development for 1 of 3 residents, R64, reviewed for pressure ulcers. Findings include: Document review of R64's most recent Minimum Data Set [MDS], dated 11/23/16, had long and short term memory problems and severely impaired cognitive skills for daily decision making. The MDS, dated 11/23/16, revealed R64 required extensive assistance from 2 or more staff for personal hygiene and bed mobility and was totally dependent on assistance from 2 or more staff for toileting and transfers. During continuous observation on 12/21/16, from 7:32 a.m. to 12:44 p.m., R64 was noted to be sitting in R64's wheelchair for 4 continuous hours without being repositioned or offloaded. At 7:32 a.m., two nursing assistants, (NA)-C and (NA)-D were observed to provide morning cares and then transferred R64 into a wheelchair. At 8:19 a.m., R64 was wheeled to the dining room. At 8:48 a.m., the nurse (RN)-G, provided care to R64 briefly in the hallway near the dining room. At 9:04 a.m. R64 ate breakfast with assistance from staff. At 9:32 a.m. R64 was finished eating breakfast, yet remained at the table. At 9:54 a.m., the activity assistant, (AA)-A, wheeled R64 onto the elevator and to the dining room for a church service. R64 remained in the dining room until 10:42 a.m. when AA-A wheeled R64 back onto the elevator and to the unit. At 10:45 a.m. RN-G provided cares near the medication cart until 10:47 a.m. R64 then sat in R64's wheelchair near the dining room table until 12:13 p.m. when NA-C wheeled R64 from the table to R64's room. NA-C	2 900	Corrected	

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2 900	Continued From page 19 and NA-D reported they had repositioned or offloaded R64 since they assisted R64 with morning cares at 7:32 a.m. At 12:19 p.m. NA-C and NA-D used a mechanical lift to transfer R64 from R64's wheelchair to bed. R64 was wheeled back to the dining room at 12:44 p.m. When interviewed on 12/21/16, at 1:49 p.m. RN-G verified did not assist R64 with repositioning or offloading that day. RN-G reported R64 should be repositioned or offloaded every 2 hours. The nurse manager, RN-F, verified staff should reposition R64 every 1 hours according to the care guide. Document review of the care area assessment (CAA), dated 3/15/16, revealed "Resident triggered for pressure ulcers related to presence of stage II, total assist with all mobility, incontinence of B & B. Resident dx include end stages of dementia, DB, HTN. Some risk factors include decreased activity and mobility, decreased sensation d/t dx [due to diagnosis] of diabetes, B&B [bowel and bladder] incontinence. The interventions include turning and repositioning q2hrs [every in bed and w/c, barrier cream to buttocks and periarea, pressure reduction mattress, abductor pillow between knees, palm protectors, foam boots. [R64] skin is intact at this time." Document review of R64's hygiene, skin and activity of daily living care plan, last revised 8/24/16, directed staff " I was admitted with a stage 2 coccyx ulcer and pink areas on my buttocks which have resolved. I also have a hx of right heel ulcer and blisters on my left arm and hand. Per Braden Assessment recently completed, I am at a high risk for developing pressure ulcers d/t [due to] these risk factors;	2 900		

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2 900	Continued From page 20 friction and shearing, contractures, decreased mobility and activity, incontinent of bowel and bladder, and dx [diagnosis of diabetes. I recently have pressure ulcer wound stage II on my left fingers (3rd,4th, 5th) possibly from friction d/t contracture. Interventions included: "Staff of 2 to turn and reposition every 2 hours in bed and wheelchair. Staff ensure comfort and assist to maintain position with pillows in bed. Use draw sheet to prevent friction/shearing with repositioning." Document review of the undated care guide, directed staff "Q1 hr [every 1 hour] reposition." Document review of the Skin Program policy, last revised 9/2016, directed staff "To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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21000	Continued From page 21	21000		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized proper hand hygiene during meal service to reduce the risk of food borne illness for all residents who ate in the first floor dining room, and the facility failed to ensure proper hand hygiene during meal preparation, which had the potential to affect all residents who eat in the facility. Findings include: During an observation on 12/19/16, at 5:50 p.m. a dietary aide (DA-A) brought food and beverages to residents in the first floor dining room. Between bringing food and beverages out of the kitchen, DA-A washed hands in the kitchen sink, then used clean hands to shut off the water before pulling a paper towel from the dispenser to dry hands. After drying hands, DA-A brought a plate of food out to a resident in the dining room. When asked about whether the facility provided hand hygiene training, DA-A said handwashing seemed pretty common knowledge, but thought that the	21000	Corrected	1/31/17

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21000	Continued From page 22 facility explained handwashing in the training before new employees start to work in the facility. During an observation on 12/19/16, at 5:56 p.m. a cook (C-B) dished up food on plates in the first floor dining room. Between plates, C-B washed hands in the kitchen sink, then used clean hands to shut off the water before pulling a paper towel from the dispenser to dry hands. C-B donned gloves and served up two plates of food. After removing the gloves, C-B washed hands in the kitchen sink for approximately five seconds, then shut off the water with bare hands before pulling a paper towel to dry hands. During an observation on 12/22/16, at 10:12 a.m. C-A made gravy for an upcoming meal service. C-A washed hands in the kitchen sink for approximately six seconds, then shut off the water with bare hands before pulling a paper towel from the dispenser to dry. C-A proceeded to touch the handle of a pot while melting butter on the stovetop, then donned gloves to cut onion on a cutting board. After cutting, C-A removed gloves and used bare hands to lift the lid of the garbage can next to the stove to dispose of the gloves and onion waste. C-A then washed hands in the kitchen sink for approximately five seconds, before returning to the pot on the stovetop. When interviewed on 12/22/16, at 10:39 a.m., the director of dietary services verified that new staff received handwashing training when they start the job, and explained staff also received monthly in-services that covered handwashing, among other things. The director of dietary services confirmed that staff should leave the water running while they dry their hands, then shut off the water using a paper towel.	21000		

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21000	Continued From page 23 Document review of the facility policy titled; Handwashing/Hygiene, revised August 2014, revealed "Employees must wash their hands for at least twenty (20) seconds." SUGGESTED METHOD OF CORRECTION: The director of nutritional services could in-service all dietary staff on the proper hand hygiene for food handlers. The director of nutritional services could perform random audits of the hygiene practices to present to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were maintained for 2 of 2 residents (R83, R86) observed for activities of daily living. Findings include: During observations on 12/19/16, the following was observed during the initial tour on the second floor ventilator care unit:	21375	Corrected	1/31/17

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21375	Continued From page 24 On 12/19/16, at 1:15 p.m. observed nursing assistant (NA)-Z leaving R83's room with gloves on holding two trash bags walking down the hallway toward R86's room and placed the bags by R86's door and entered R86's room with the same gloves on. NA-Z took the gloves off while in R86's room and came out of that room at 1:17 p.m. On 12/19/16, at 1:23 p.m. NA-Z acknowledged came from R83's room, walking in the hallway with gloves on and holding two trash bags and entered R86's room after placing the trash bags by R86's door. Removed gloves while in R86's room. During an interview on 12/21/16, at 2:20 p.m. registered nurse (RN)-C. stated the facility expectation was that all staff should remove gloves when finished from one resident's room to another and after doing cares to prevent contamination. RN-C added, Staff should not wear gloves in the hallway unless actively cleaning up bodily fluids. Document review of the facility policy and procedure titled, GLOVE USE, with revision date; May 2014, indicated, "6. When resident care complete, gather soiled items in linen bag or waste container and contain. Remove gloves, WASH HANDS, take soiled bagged items to appropriate soiled room. Once placed, WASH HANDS again." Document review of the facility policy and procedure titled, HANDWASHING/HYGIENE with revision date; August 2014, stated, "5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. Before and after direct resident contact (for which	21375		

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21375	Continued From page 25 hand hygiene is indicated by acceptable professional practice); h. Before and after assisting a resident with personal care (e.g., oral care, bathing); After removing gloves or aprons". SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies and procedures related to infection control, specific to wearing gloves in the hallway from resident's room to another resident's and hand washing techniques, train staff and monitor to assure proper techiniques are being utilized. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		1/31/17

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21426	Continued From page 26 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the agency failed to ensure 1of 5 employee files reviewed, had proper documentation of results as directed by State Tuberculosis Guidelines. Findings include: Document review of the maintenance (E5) file, revealed a start date of 8/15/16. The file revealed Employee/Candidate Mantoux (TST) Questionnaire was completed, a step 2 TST's were read 8/21/16, and 9/2/16, with results as "size 0 [millimeter] mm 0 mm of induration." The TST's that had been administered lacked the interpretation (read as either positive or negative). When interviewed on 12/21/16, at 1:40 p.m. registered nurse (RN)-C verified the TST's that had been administered lacked the interpretation (read as either positive or negative). Furthermore, RN-C added, "We are also planning to have monthly in-services for nurses and I will bring it up". Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCWs) directed "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative	21426	Corrected	

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21426	Continued From page 27 Interferon-Gamma Release Assays [IGRA] (blood test) or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients... Serial TB screening Serial TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a one-step TST or single IGRA... General principles ·All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee's record. ·TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative) ..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		

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21665	Continued From page 28	21665		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on document review, interview, and observation, the facility failed to provide a comfortable odor free room environment for resident (R55) and failed to ensure the environment was maintained in a safe and comfortable manner for 9 of 10 residents (R160, R140, R91, R166, R103, R50, R157, R155, R159) reviewed for environmental concerns. Findings include: R55's most recent Minimum Data Set (MDS), dated 10/10/16, revealed R55 was cognitively intact and did not transfer from bed or other surfaces. On 12/20/2016, at 9:41 a.m., R55 reported the urine smell in the room gave R55 headaches. R55 reported was unable to leave the room and the condition of the room made R55 "very depressed", adding "I got no choice. Anyone else can come in and leave." R55's room was noted to have a strong foul urine odor. R55 also expressed concern as was vulnerable to infection and did not feel the condition of the room was sanitary, based on observations of odors. On 12/22/16, at 9:53 a.m., R55's room again had a strong foul urine odor. On 12/22/16, at 9:35 a.m. during environmental tour with the maintenance director (MD) and environmental director (ED), the following concerns were noted.	21665	Corrected	1/31/17

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21665	Continued From page 29 R55's room was observed to have a strong foul urine odor. R55 stated can't you smell it, gets headaches from the smell, but had no headache now. Registered nurse (RN)-F indicated had been working with staff to clean the room. RN-F stated R105 will pull catheter out, staff can't help it, and that contributed to the smell. RN-F stated staff will strip bed and clean the room three to four times a day. ED confirmed the room was a concern with staff cleaning it three to four times a day. On 12/22/16, at 9:35 a.m. during environmental tour with the maintenance director (MD) and environmental director (ED), the following concerns were noted and verified: On 12/20/16, at 12:31 p.m. R160's room was observed to have two pillowcases covering R160's pillow. R160 asked staff to double up pillow cases because there often were stains on the linens. The pillowcase had light brown stains on the inside pillowcase. On 12/20/16, at 10:57 a.m. R140 was observed to have a stain on a sheet being used for a window covering to keep the breeze out. On 12/20/16, at 1:10 p.m. R91's room was observed with small areas of paint peeling on the wall near the bed. In addition, the wood molding had several chips in it. On 12/19/16, at 4:46 p.m. R166's room door was observed with several jagged pieces along the inside edge. The window sill nails were jutting out from the bottom side of the sill. The head of bed was next to the window sill, which was falling apart on the underside. The bathroom door had broken off and the Formica had jagged edges.	21665		

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21665	Continued From page 30 On 12/19/16, at 5:47 p.m. R103's room window blinds were observed with holes measuring approximately 4 inches by 4 inches on the right and left sides of each. The room was cluttered with a bin of clothes near the window and R103 stated they needed name labels and should go to the wash. On 12/19/16, at 5:08 p.m. R103 stated his room was cold. On 12/20/16, at 11:45 a.m. R50's room door was observed to not close, the inside handle was loose and there were several holes midway up the hallway wall near the bed. On 12/20/16, at 11:59 a.m. R160's bathroom was observed to have a dirty air vent. R160 stated she placed a towel on the shower room chair to sit on it, a towel on the floor for her feet, and would not allow her body to touch the dirty surfaces. On 12/20/16, at 8:49 a.m. R157 stated room was cold next to the window by the bed and there was a draft. On 12/20/16, at 12:35 p.m. R155 stated at night the room was cold and thought the window leaked a bit. On 12/19/16, at 4:30 p.m. R159 stated the room was cool, told staff, but it still was cold. During an interview on 12/22/16, at 1:49 p.m, a family member of R159 (F)-Q, noted cracks in the floor near the window and marks on the floor. F-Q reported the floor had been that way since R159 was admitted, and F-Q did not think it was in satisfactory condition.	21665		

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21665	Continued From page 31 When interviewed on 12/22/16, at 10:58 a.m. MD stated would go into a room for maintenance checks when it was vacant and checked blinds, doors, and all other things. MD stated every nurse station had a maintenance request book where staff entered maintenance requests. Additional maintenance staff checked the request books daily at 1:00 p.m. Document review of an undated policy titled, Room Readiness Check List Housekeeping check list directed: "wipe down bed frame, head and foot boards, mattress, side rails... Sweep and mop floor checking corners, edges, and behind the door... Record any maintenance issues. Document reivew of Audit Tool - Environmental directed: "Directions: Random weekly audits for environmental to ensure facility maintains a sanitary, orderly, and comfortable interior" No maintenance policy was provided for preventative maintenance routines. SUGGESTED METHOD OF CORRECTION: The administrator or director of environmental services or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The administrator or director of environmental services or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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	00913	A. BUILDING: _____ B. WING _____	C 12/22/2016

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21695	Continued From page 32	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review,the facility failed to ensure 3 of 4 floors (2nd, 3rd and 4th) carpet was maintained, cleaned and free of odor for residents who resided on and/or visited the floors. Findings include: On 12/22/16, at 9:35 a.m. during environmental tour with the maintenance director (MD) and environmental director (ED), the following concerns were noted and verified. The carpet on 2nd, 3rd and 4th floors were observed to be worn, torn and soiled. The third floor carpet was most noticeably observed to have a strong, urine-like odor permeating throughout the unit and a large round stain observed near the shower room door. On 12/19/16, at 4:46 p.m. the carpet outside R166's room had a musty urine-like odor. When interviewed on 10/22/16, at 10:58 a.m. MD stated every nurse station had a maintenance request book where staff entered maintenance requests. Additional maintenance staff checked the request books daily at 1:00 p.m. Document reivew of Audit Tool - Environmental directed: "Directions: Random weekly audits for	21695	Corrected	1/31/17

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21695	Continued From page 33 environmental to ensure facility maintains a sanitary, orderly, and comfortable interior." No maintenance policy was provided for preventative maintenance routines. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The Administrator or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure a dignified environment for 2 of 4 residents (R140, R160) reviewed for dignity by not providing furniture to accommodate residents of all sizes, and by not ensuring resident privacy from the window view in the shower room. Findings include:	21805	Corrected	1/31/17

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21805	Continued From page 34 Document review of the electronic medical record (eMR) revealed R140 was admitted to the facility on 7/21/2016. R140 was assessed as cognitively intact during the quarterly minimum data set (MDS) assessment 11/10/16. R140 weighed 486 pounds on 12/21/16, as documented in the electronic medical record. During an observation on 12/20/16, at 10:05 a.m. R140 was laying in bed. R140's room furnishings lacked seating other than the resident's bed and wheelchair. R140 said the facility did not have a chair to sit in yet, and did not think a wheelchair counted as a normal chair. Since being admitted in July, R140 did not feel able to get in and out of the wheelchair safely, explaining "I can't get my legs underneath me to get out of the wheelchair on my own." R140 said that the last time two staff tried to assist with the transfer out of the wheelchair, R140 fell back down onto the wheelchair, hit backside of body on the chair, and snapped head back after falling on the wheelchair. R140 said it took six facility staff to get R140 back up again. During an observation on 12/21/16, at 8:24 a.m. R140 was eating breakfast in bed. When asked whether R140 preferred eating in bed, R140 explained eating in bed because the main dining area on the unit did not have chairs to accommodate weight/size. When asked whether R140 was interested in spending time in the common area, R140 stated, "I want to get out there! But they aren't even bothering to get me a real chair out there. They tell me I can sit in my wheelchair, but I don't want the wheelchair! I want a real chair." At 2:03 p.m. R140 described speaking about wanting a bigger chair to "anyone and everyone," but that eventually staff said they	21805		

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21805	Continued From page 35 couldn't find one. During an interview on 12/21/16, at 2:39 p.m. the occupational therapist (OT) explained the facility was unable to find a wheelchair to accommodate R140 that was covered by insurance. Furthermore, the OT verified the facility currently did not have a chair that was wide enough to accommodate R140. During showers, R160 was not provided dignity of privacy from view of the window to the outside property. Document review of the quarterly MDS, dated 12/6/16, indicated R160 was cognitively intact. During an interview on 12/20/2016, at 11:57 a.m. R160 described a courtyard outside that residents used as a smoking area. R160 said from this courtyard, you can look up at the window in the fourth floor shower room and see the silhouette of the person in the shower room. R160 said it was possible to tell if the person in the shower room was male or female, and mentioned asking staff for curtains multiple times. R160 said staff tried to reassure that it was not possible to see anything from the courtyard outside, even though R160 insisted on seeing the body outlines from the courtyard. During an observation on 12/21/16, at 1:39 p.m. the fourth floor shower room was observed to have two shower stalls separated by a curtain. The shower stall farthest from the doorway was against the outside wall of the building. This wall had a large window with frosted glass that overlooked the courtyard below. The window started approximated 1.5 feet up from the floor, was approximately 4 feet wide, and approximately	21805		

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21805	Continued From page 36 5 feet tall. The window lacked a curtain. During an observation from the courtyard on 12/21/2016, at 2:34 p.m. the fourth floor shower room window was visible from the courtyard below. From the courtyard, a registered nurse (RN-A) looked up at the window while someone stood in the shower room. The figure of the person in the shower room was visible. RN-A verified it was possible to see the outline of the person while looking up from the courtyard. RN-A confirmed staff would contact maintenance to hang a curtain in the window for privacy. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff on resident dignity and respect. The director of nursing or designee could perform random audits to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the	21880		1/31/17

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21880	Continued From page 37 Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that prompt efforts were made by the facility to resolve grievances for 1 of 1 resident (R88) reviewed, who expressed a grievance to facility staff. Findings include:	21880	Corrected	

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21880	Continued From page 38 When interviewed on 12/19/16, at 6:45 p.m. R88 expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance and that a care conference was supposed to have been scheduled and that had not happened yet either. During an interview with R88 on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16 and no family care conference had been set up as the facility had said they would do 12/2/16. Document review of the quarterly Minimum Data Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer, anxiety, asthma and depression. Document review of the form titled; Grievance Form, dated 12/2/16, read, "Resident reported someone (nurse or nurse aide) left [R88] in [R88] wheelchair for a long time without transferring [R88] to [R88] bed. [R88] also reports they keep forgetting to give [R88] showers. Resident has stated [R88] either has or would like to call Welcov Corporate to voice [R88] concerns. The section which reads; Action taken to address Grievance: read, Reported to MDH (Minnesota Department of Health) Investigation initiated. Care Plan meeting being set up by social services with resident and [R88] family. The responsible person signature on the form was the Director of Nursing (DON) and dated 12/5/16. The administrator signed the Grievance form 12/5/16.	21880		

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21880	Continued From page 39 Document review of the policy titled Grievance/Concern, Revision date: July 2015, indicated a written report of investigation and recommended action will be completed and returned to Administrator/Social Service Director within 72 hours. A meeting with the resident/representative will occur to review the findings and actions taken and/or those that will be taken. If they are not satisfied with the results, other actions will be developed as needed. During an interview with the DON and Administrator on 12/22/16, at 8:40 a.m. verified they were not aware of the follow up and did not have any other documentation for investigation of the 12/2/16, concern. During an interview on 12/22/16, at 11:30 a.m. with the current social worker (SW)-A who had been working as a temporary fill in social worker since 12/11/16, verified no knowledge of the resident or family anticipating a meeting to discuss concerns. SW-A was not aware to set up a meeting with the resident or family. Furthermore, SW-A verified not seeing the Grievance/Concern for R88 and not being informed of the follow up required. SW-A verified the facility did not follow up with a care conference for the resident and family to discuss care concerns but SW-A would follow up immediately. SUGGESTED METHOD OF CORRECTION: The director of social services/nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievances. Then develop monitoring systems to ensure ongoing compliance and	21880		

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21880	Continued From page 40 report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to make an annual attempt at forming a family council. This had the potential to impact all residents in the facility. Findings include: On 12/22/16 at 2:58 p.m., the activities director reported the facility did not have a family council. The activities director reported he was newly in charge of family council and had no evidence the facility made an attempt to form a family council within the past calendar year.	21942	Corrected	1/31/17

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21942	Continued From page 41 A policy was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The activity director or designee could make an attempt to form a family council and review and revise related policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations of mistreatment, neglect and abuse are thoroughly investigated, reported to the administrator immediately and reported immediately to the state agency for 1 of 3 residents (R55) reviewed for incidents. Findings include:	21995	Corrected	1/31/17

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21995	Continued From page 42 R55 reported on 9/7/16, at 8:11 p.m. that the nurse threatened to take away the oxygen and the incident was not reported to the administrator or state agency until 9/12/16, at 12:00 p.m. R55 was assessed as cognitively intact according to the minimum data set (MDS) annual review 10/10/16, and diagnoses from the MDS included coronary artery disease, heart failure and hypertension. R55 had a physician order for 3 liters of oxygen via nasal cannula (nc) continuously due to chronic obstructive pulmonary disease. According to the document titled, Progress notes, written by registered nurse (RN)-I dated 9/7/16, at 8:11 p.m. read; Writer notified of incident and spoke with the patient who verbalized, "the nurse cannot take away my oxygen, where is the doctors order". Pt was upset and speaking very loud. Writer apologized for any misunderstanding and ensured pt that the oxygen would remain in [R55] room and we will do anything we can to ensure [R55] is comfortable and safe. Pt further verbalized that [R55] did not want the nurse in [R55] room "ever again". Writer continued to comfort pt and assured pt that this nurse would stay out of [R55] room. Pt thanked writer and verbalized being comfortable and without pain or SOB [shortness of breath]. O2 [oxygen] sats [saturation] 94% on 3 L [liters] O2 via nc. Writer spoke with nurse and ensured that [RN-J] would remain out of the patients room the remainder of the shift and we would follow up tomorrow. Nurse verbalized understanding. No further issues noted. According to the document titled, Progress notes, written by RN-J dated 9/7/16, at 6:42 p.m. read,	21995		

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21995	Continued From page 43 Behavior: Patient threatened writer and NAR [nursing assistant registered] after walking to patients room to verify the oxygen compressor was for another resident. Patient was aggressive (threw a cup at me) and abusive using all the words in the book. Writer told the incident to other nurses working on the unit. Will monitor residents behavior. According to the document titled, Internal Investigation Form, on 9/12/16, at 12:00 p.m. the mental health practitioner reported to the administrator and director of nursing that R55 expressed the incident on 9/7/16 where the charge nurse pointing finger in res face and threatening to take O2 from the resident. During an interview on 12/22/16, at 8:40 a.m. with the administrator and director of nursing (DON) verified RN-I failed to follow the facility policy to report abuse immediately to the administrator and the state agency on 9/7/16, at 8:00 p.m. failed to immediately start an internal investigation and failed to inform them of the situation until the mental health practitioner reported the abuse on 9/12/16, at 12:00 p.m. Furthermore, no written statement was obtained or interview conducted from the NAR reported as a witness. Document review of the facility policy revision dated, Nov 2016, and titled, Abuse Prevention Plan, read; "The administrator is ultimately in charge of the Abuse Prohibition Plan and must be informed of all alleged or substantiated incidents of abuse, neglect, or maltreatment immediately. In the case of the administrator being unavailable, the designee will be notified in this timeframe. The State Agency must be notified immediately". Furthermore, for Investigation the document directed the facility staff would complete an	21995		

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21995	Continued From page 44 incident report by a licensed staff immediately following the incident. The unit manager/night supervisor would implement immediate changes to keep the resident safe, with follow up implementation reviewed to make sure that they are appropriate for the resident and condition of resident. Under the Internal Reporting the policy directed; 1. All incidents that are suspicious in nature will be investigated by the internal process. 2. Upon receipt of the report, the DNS or designee on duty will begin investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document such findings. 3. That documentation will include the following; Identify the resident, identify the caregiver, Time, date and location of suspected maltreatment, Nature and extent of the suspected maltreatment, Any other information believed helpful in investigating the suspected maltreatment. Facility will accomplish this by completing the accident/Incident report or issue and concern form. Analyze the occurrences to determine what changes are needed is any to policy and procedures to prevent further occurrences. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff on the directions in the maltreatment statute to report abuse immediately to the Common Entry Point (Office of Health Facility Complaints). Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		