PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 14, 2016

Ms. Tracy Hendrickx, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

Subject: Golden LivingCenter - Walker - Informal Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5323
Project Number: S5323025

Dear Ms. Hendrickx:

This is in response to your letter of August 8, 2016, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency cited at F250, issued pursuant to the survey completed on July 15, 2016.

The information presented with your letter, the CMS 2567 dated July 15, 2016, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F250 G 42 CFR §483.15 (g) Social Services 483.15 (g) (1) The facility must provide medically related social services to attain and maintain the highest practicable physical, mental and psychosocial being of each resident.

Summary of the facility's reason for IDR of this tag.

The facility alleges they provided medically related social services to R12 when R12 experienced mood and sleep changes following a roommate change. The facility further alleges they were in the process of supplying a wall mounted television for R12's roommate R18, because they were aware there was conflict between R12 and R18 regarding the television. Facility staff stated they felt adding a television to the room would be the least disruptive to the situation for both residents and would solve their conflict.

Summary of facts.

R18 was moved into R12's room on 6/22/16. According to the record, and staff and resident interview, R12 and R18 experienced several conflicts between them related to television usage and daily routines such as choice of bed time and rising time routines. Various facility staff were aware of these conflicts including the SW, NA-A, NA-E and LPN-B. Due to the conflict which began between R12 and R18 after the roommate change, R12 began to demonstrate irritability, fatigue, sleepiness and spent less time in

his room which represented changes in his demeanor. The interpersonal conflicts continued and were observed by the surveyor on July 12, 2016 at 9:15 a.m. In addition, when interviewed, staff stated they were aware of R12's changes in demeanor, and verified R12 spent less time in his room because of R18's treatment of him. Staff acknowledged R12 had become irritable and was not sleeping well. When interviewed, the SW was aware R12 and R18 did not get along as roommates, and verified R12's family had expressed concern about R12 not sleeping well since the roommate change.

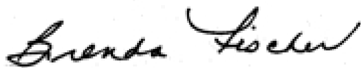
Summary of findings:
There was no indication in R12's record the SW had comprehensively assessed the conflict between R12 and R18. Other than initiating the addition of another television to the room, there was no evidence the SW had considered other options to improve the relationship between R12 and R18. Multiple staff were aware of the conflict between the two residents and of the changes in R12's demeanor since R18 had become his roommate. The federal regulation guidance for psychosocial scope and severity at a level 3 (harm) includes: negative psychosocial outcome as a result of the facility's noncompliance may include but not be limited to persistent depressed mood, and may be manifested by verbal or nonverbal symptoms such as: social withdrawal, irritability, anxiety and hopelessness. R12 had displayed these types of mood changes which facility staff were aware of.

This is a valid deficiency cited at F250 and at the correct scope and severity of G, actual harm.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
3333 West Division Street, Suite 212
St Cloud, MN 56301
Telephone: 320-223-7338 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Lyla Burkman, Bemidji District Office Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZI3W
Facility ID: 00995

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245323**

2. STATE VENDOR OR MEDICAID NO.
(L2) **677088600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WALKER**
(L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
(L5) **WALKER, MN** (L6) **56484**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **09/08/2016** (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 **40** (L18)

13. Total Certified Beds **40** (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
	40			
(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 :
Yvonne Switajewski, HFE NEII — 09/15/2016 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(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.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/18/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245323

October 25, 2016

Ms. Tracy Hendrickx, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

Dear Ms. Hendrickx:

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

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

Effective August 16, 2016 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 15, 2016

Ms. Tracy Hendrickx, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

RE: Project Number S5323025

Dear Ms. Hendrickx:

On July 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 15, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On September 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 15, 2016, effective August 16, 2016 and therefore remedies outlined in our letter to you dated July 29, 2016, 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 related to this eNotice.

Sincerely,

Mark Meath

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

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

An equal opportunity employer.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245323		9/8/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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 F0247 Reg. # 483.15(e)(2) LSC	Correction Completed 08/16/2016	ID Prefix F0250 Reg. # 483.15(g)(1) LSC	Correction Completed 08/16/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 08/16/2016
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 08/16/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 08/16/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 08/16/2016
ID Prefix F0387 Reg. # 483.40(c)(1)-(2) LSC	Correction Completed 08/16/2016	ID Prefix F0411 Reg. # 483.55(a) LSC	Correction Completed 08/16/2016	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 08/16/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 08/16/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 08/16/2016	ID Prefix F0504 Reg. # 483.75(j)(2)(i) LSC	Correction Completed 08/16/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) LB/mm	DATE 09/15/2016	SIGNATURE OF SURVEYOR 18619	DATE 09/08/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/15/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 15, 2016

Ms. Tracy Hendrickx, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

Re: Reinspection Results - Project Number S5323025

Dear Ms. Hendrickx:

On September 8, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 15, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

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

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00995 Y1	A. Building B. Wing Y2	9/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20302 Reg. # MN State Statute 144.6503 LSC	Correction Completed 09/08/2016	ID Prefix 20435 Reg. # MN Rule 4658.0210 Subp. 2 A.B. LSC	Correction Completed 09/08/2016	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 09/08/2016
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 09/08/2016	ID Prefix 21290 Reg. # MN Rule 4658.0710 Subp. 3 A LSC	Correction Completed 09/08/2016	ID Prefix 21325 Reg. # MN Rule 4658.0725 Subp. 1 LSC	Correction Completed 09/08/2016
ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. 4 A-I LSC	Correction Completed 09/08/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 09/08/2016	ID Prefix 21495 Reg. # MN Rule 4658.1005 Subp. 5 LSC	Correction Completed 09/08/2016
ID Prefix 21530 Reg. # MN Rule 4658.1310 A.B.C LSC	Correction Completed 09/08/2016	ID Prefix 21550 Reg. # MN Rule 4658.1325 Subp. 1 LSC	Correction Completed 09/08/2016	ID Prefix 21615 Reg. # MN Rule 4658.1340 Subp. 2 LSC	Correction Completed 09/08/2016
ID Prefix 21942 Reg. # MN St. Statute 144A.10 Subd. 8b LSC	Correction Completed 09/08/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) LB/mm	DATE 09/15/2016	SIGNATURE OF SURVEYOR 18619	DATE 09/08/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/15/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

 EVENT ID: ZI3W12

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZI3W

Facility ID: 00995

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245323**

2. STATE VENDOR OR MEDICAID NO. (L2) **677088600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WALKER**
(L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
(L5) **WALKER, MN** (L6) **56484**

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) **04/01/2006**

6. DATE OF SURVEY **07/15/2016** (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 **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Jana Bromenshenkel, HFE NE II 08/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/16/2016 (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 **07/01/1986** (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. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 29, 2016

Ms. Tracy Hendrickx, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

RE: Project Number S5323025, H5323015 and H5323016

Dear Ms. Hendrickx:

On July 15, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5323015 and H5323016.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 15, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5323015, H5323016 that were found to be unsubstantiated.

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 August 24, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 24, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the

criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 15, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 15, 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.

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

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

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING ______ B. WING ______	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	**209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484**

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaints H5323015 and H5323016 were completed and found not to be substantiated.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 1 of 2 residents (R12) with the appropriate notification of a roommate change. Findings include: On 7/12/16, at 9:50 a.m. R12 stated R18 had	F 247	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	8/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/04/2016

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

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F 247	Continued From page 1 moved into his room about a month ago (R18 moved in with R12 on 6/22/16). R12 stated he had not been notified of the roommate change prior to R18 moving in. On 7/14/16, at 10:00 a.m. social worker (SW) confirmed when a resident moved into a room which had a resident already occupying that room, two forms were to be competed. SW confirmed one form was completed by the resident requesting or being asked to make the room change and the second form was completed and given to the resident as notification that they would be receiving a new roommate. SW stated if both residents agreed to the move, then the move could occur right away. However, if one of the residents hadn't agreed to the move, then there was a seven day adjustment period before the move occurred. SW verified R12 (resident who received a new roommate) had not been provided or signed the Notice Getting A Roommate form. SW stated she had been on vacation when R18 moved into R12's room and SW was unsure of who followed through on the notification of roommate and/or room changes in the SW's absence. SW confirmed any time there was a conversation regarding a room/roommate change that conversation should be documented in the residents' medical record. SW confirmed R12's medical record lacked documentation regarding notification of R12 getting a roommate. SW verified R12 had told her that he (R12) had not been made aware that he would be getting a roommate prior to R18 moving in. SW confirmed R18 had been given notice of the room change on 6/15/16. R18 had refused to sign the notice, so the seven day adjustment period was provided	F 247	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F247 -Room changes have been completed for R12 and R18. Proper notice of room change has been completed and documented. -All residents with a change of room or roommate have the potential to be affected if proper notification of said change is not communicated and documented. -SSD has been re-educated on requirements for notification of room/roommate change and necessary follow-up following change in room/roommate. -Audits will be completed after each room or roommate change for the next 30 days to insure proper notice and follow-up has been completed. Negative findings will be immediately corrected. Audit results will be reviewed at QAPI for	

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F 247	Continued From page 2 with R18 moving into R12's room on 6/22/16. On 7/14/16, at 10:29 a.m. the administrator confirmed prior to a resident room change and/or roommate change the appropriate notification should be provided. The administrator stated potential roommate compatibility was taken into consideration prior to a roommate change and she expected all conversations regarding room/roommate changes to be documented in the appropriate medical record. The administrator confirmed the SW was the one who made sure the appropriate notifications were given and signed and would document these conversations in the residents' medical record. R12's nursing progress notes (PN) from 6/15/16, through 7/13/16, lacked documentation of appropriate notification of a roommate change or a follow up assessment of the roommate change. Resident Room Relocation policy dated 2/26/15, indicated the social service staff would be involved with any resident room relocations. The resident's social, emotional and cognitive needs would be assessed and considered prior to relocation of the resident. The impact of room relocation on the resident's psychosocial status would be assessed by the social service staff. The social service staff would work with the interdisciplinary team to consider roommate compatibility to arrive at the most appropriate location for a resident. In addition, a plan would be developed by the social service staff to assure the needs and concerns related to the residents' ability to cope and adjust to the relocation would	F 247	recommendations and to determine continued need for audits. -The ED/Designee is the responsible party. -Corrective action will be completed by August 22, 2016.	

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F 247	Continued From page 3 be addressed by: - A verbal noticed would be provided to the resident or family that was being relocated and this would be documented in the medical record. - Room options would be given when possible. - Resident would be introduced to their new roommate. - The resident and/or their family would be informed that they were receiving a new roommate. - The identified social, emotional, and cognitive need related to the room relocation would be addressed. - A follow up visit would made as needed by the social service staff to aid in the adjustment to the move. - Social service staff would document the resident's response to the move in the medical record. General Guidelines for Transfer of Resident within the Facility policy dated 5/3/16, indicated the residents or their responsible parties would be notified in advance of the transfer. All roommates affected by the transfer would be notified. A change of room or roommate notice would be provided. In addition, how well the resident tolerated the move should be documented.	F 247		
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		8/22/16

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F 250	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services to promote the psychosocial well-being for 2 of 2 residents (R12, R18) who had unresolved roommate conflicts. R12 experienced psychosocial harm due to persistent sleep disturbance and decline in mood. Findings include: R12's physician progress note dated 6/14/16, identified R12's diagnoses as history of a heart attack, heart failure, hypertension, obstructive sleep apnea (a disorder where breathing repeatedly stops and starts which occurs when the throat muscles relax), cerebral vascular accident (stroke) with left-sided weakness. R12's quarterly Minimum Data Set (MDS) dated 5/17/16, indicated R12's cognition was intact, had no signs and symptoms of a mood disorder, no behavior exhibited towards self or others during the assessment period. R12 required extensive assist with bed mobility, transferring, toileting and personal hygiene. R12 was independent with locomotion off the unit. R12 was always continent of bladder. R12's care plan dated 9/14/16, identified an area of focus regarding R12's safety and potential for abuse due to R12's decreased physical mobility. Interventions included not having R12 near others	F 250	F250 -SSD has assessed psychosocial well-being of R12 and R18. R12 and R18 are no longer roommates. -All residents with unresolved conflicts have the potential to be affected if not provided social services to promote psychosocial well-being. -SSD was re-educated on provision of psychosocial services for residents with unresolved conflicts. IDT was provided education on identification and resolution of resident conflict. -Audits will be completed on 3 residents weekly to determine if there are unresolved room/roommate conflicts. Negative results will be reviewed/resolved by IDT immediately. Audit results will be reviewed at QAPI for recommendations and to determine continued need for audits. -The ED/Designee is the responsible party. -Corrective action will be completed by August 22, 2016.	

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F 250	Continued From page 5 who disturbed him and that R12 should be removed from any potentially dangerous situations. In addition, R12's care plan indicated R12 was at risk for sleep pattern disturbances and directed staff to maintain an environment conducive to sleep (quiet, comfortable temperature, dimmed lights). R12's Medication Administration Record (MAR) indicated R12 received Lasix (a diuretic) 20 milligrams (mg) daily. In addition, melatonin 10 mg daily for insomnia. R18's Diagnosis Report dated 7/14/16, identified R18's diagnoses as obstructive sleep apnea, end stage renal disease, dependent on renal dialysis, and major depression. R18's admission MDS dated 5/12/16, indicated R18 had intact cognition, was on dialysis, received a daily antidepressant, had no signs and symptoms of a mood disorder, and no behavior exhibited towards self or others during the initial assessment period. On 7/12/16, at 9:15 a.m. during the initial resident interview with R18, R12 (R18's roommate), knocked on the resident's room door. R12 asked if he could come in as he (R12) had to go to the bathroom. R18 loudly responded, with R12 seated in his motorized wheelchair right outside the open door, "tell him to stay out he [R12] always has to use the bathroom." R12's request was granted and R12 entered the room, made his way to his side of the room, used the urinal and	F 250		

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F 250	Continued From page 6	F 250		

exited the room. On R12's way out, the surveyor asked if she could talk to him later. R12 stated that would be okay and that he (R12) would be in the family room.

On 7/12/16, at 9:29 a.m. the interview with R18 resumed. R18 stated R12 went to bed at 7:30 p.m. and wanted to get up at 5:00 a.m. R18 stated he [R18] normally went to bed around 10:00 p.m. and didn't get up until right before breakfast at 8:00 a.m. R18 stated R12 didn't want R18 to watch the television but "he [R18] watches it anyway." R18 stated his roommate was an "ass." R18 stated R12 spent most of his time out of the room and down by the desk. R18 stated, "It has been this way since he [R18] had moved in." R18 stated the staff were aware of the roommate situation, but the facility hadn't offered a room change. R18 confirmed that words had been exchanged between himself and R12. R18 stated he did not feel threatened by R12 and stated he "would beat the hell out of him if he [R12] tried to threaten me."

On 7/12/16, at 9:50 a.m. R12 stated R18 moved into his [R12] room about a month ago. R12 stated R18 always wanted to dominate him. R12 stated R18 "tells me what to do all the time." R12 stated R18 was not happy with him [R12] at all. R12 stated R18 liked to sit up with the television on all night long and that R18 didn't understand that he [R12] couldn't sleep with the television on all night. R12 stated he had told R18 a couple of times to "get off my back." R12 stated R18 didn't like it because he [R12] had to go to the bathroom frequently. R12 stated R18 dominated the television, so R12 stated he spent most of his

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F 250	Continued From page 7 time out of the room and watched television down in the facility family room. R12 stated he hadn't said anything to anyone, however, the nursing assistants were aware of his roommate situation. R12 stated when R18 went to dialysis, he [R12] "sneaks back in the room as much as I can." R12 stated he was not afraid of R18. R12 stated he had not been notified of the roommate change prior to R18 moving into the room. -On 7/12/16, at 1:14 p.m. R12 was seated in his motorized wheelchair in the family room. -On 7/13/16, at 7:00 a.m. R12 was observed seated in his motorized wheelchair in the family room. R18 was laying in his bed in their room sleeping with the television off. -At 7:50 a.m. R12 entered their (R12 and R18's) room and used the urinal. R12 immediately exited their room after using the urinal, leaving the urinal on R12's bed side table. R12 proceeded to go back into the family room. -At 7:56 a.m. R12 was seated in his motorized wheelchair in the family room. R12's left arm dangled down onto R12's lap and both feet positioned on the foot rest with R12's heels together and legs bowed outward. R18 remained in bed sleeping in their room. -At 8:08 a.m. R12 remained seated in his motorized wheelchair in the family room. R12 had positioned a U-shaped neck pillow around the nape of R12's neck. R12's eyes were closed and his chin was down towards his chest. -At 8:19 a.m. R12 remained sleeping while seated in his motorized wheelchair in the family room, while R18 had woken up and had been served breakfast in their room.	F 250		

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F 250	Continued From page 8 -At 8:27 a.m. R12 remained seated in his motorized wheelchair in the family room. R12 stated he would rather spend time in his room than in the family room, so he could lay down and take a nap. R12 stated R18 went to dialysis three times a week, but he [R12] wasn't aware of R18's dialysis schedule. R12 stated when he knew R18 was gone to dialysis, he spent more time in their room. R12 stated his motorized wheelchair was not comfortable to sleep in as the wheelchair was too small for him (R12 had been measured for a new wheelchair and a new motorized wheelchair was on order). -At 9:05 a.m. R12 was sleeping while seated in his motorized wheelchair. R12's neck pillow had slightly moved off to one side. -At 9:21 a.m. R12 was more slumped over while seated in his motorized wheelchair, sleeping. On 7/13/16, at 11:52 a.m. licensed practical nurse (LPN)-B confirmed R12 and R18 did not get along. LPN-B stated she had heard that R18 had made the statement that he was going to continue to be mean to R12 until he [R18] got his way. LPN-B confirmed R12 spent a lot of time out of his room now. LPN-B stated she had not observed R18 being mean to R12, however, she had heard from other staff that R18 was mean to R12. On 7/13/16, at 12:56 p.m. nursing assistant (NA)-E stated R12 and R18 got along like "oil and water" and were "polar opposites." NA-E stated R12 was in the room first and about a month ago R18 had moved in. NA-E stated R12 liked to sleep at night and R18 was more of a night owl. NA-E stated R12's and R18's sleep hours did not	F 250		

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F 250	Continued From page 9	F 250		

match up. NA-E stated R12 spent more time in the family room since R18 moved in because R12 didn't want to be around R18. NA-E stated she was aware of times when R18 told R12 to "F-off" and R12 had told R18 to mind his own business. NA-E confirmed verbal exchanges had occurred between R12 and R18, but nothing physical. NA-E stated R12's mood and demeanor had changed since R18 had become R12's roommate. NA-E stated R12's mood had become more hostile towards the staff. NA-E stated she had informed the administrator a couple of weeks ago about how R18 had been treating R12 and that putting them together had been the worst decision. NA-E stated nothing had changed though since she had brought it to the administrator's attention. NA-E stated the nursing assistants were not asked to provide input with potential room or roommate changes. NA-E state it was hard to see someone (R12) who had been so happy to now go to being a total grump all the time.

On 7/13/16, at 1:08 p.m. NA-A confirmed R12 and R18 did not get along as roommates. NA-A stated R18 liked to be up at night and R12 liked to go to bed earlier. NA-A stated R18 had sworn at R12 when R12 had to use the urinal so much. NA-A stated she had noticed a difference with R12 since R12 and R18 had become roommates. NA-A stated R12 was shorter with staff now and he (R12) used to be happier. NA-A stated R12 used to get up in the morning around 5:00 a.m. - 5:30 a.m. and now R12 doesn't get up until around 6:30 a.m. - 7:00 a.m. NA-A stated she thought R12 still woke up around 5:00 a.m., but now just lied awake until 6:30 - 7:00 a.m. when he (R12) felt it was okay to get up and not disturb

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F 250	Continued From page 10 his roommate (R18). NA-A stated before R12 and R18 became roommates, R12 would lay down a lot more and usually took a nap in his room or would just kick back in his wheelchair and watch television in his room. NA-A stated now R12 spent most of his time out of his room and in the family room. NA-A stated sometimes when R18 was at dialysis, R12 would go into his room and laid down. NA-A stated when R18 hollered at R12, R12 just put his head down and doesn't respond to R18, it's like he [R12] was just trying to ignore R18. NA-A stated the NAs used to provide input regarding potential room or roommate changes, however, the NAs hadn't been asked in a long time to provide input. NA-A stated it wasn't a good idea to put R12 and R18 together. NA-A stated she thought this move had definitely impacted R12 more than R18, and in a negative way. On 7/13/16, at 2:07 p.m. NA-F stated R12 and R18 argued about the television a lot. NA-F stated R12 used to go to bed right after dinner and now R12 doesn't go to bed until about 8:00 p.m. (staying up about two hours later than R12's past preference/routine). NA-F stated R12 used to go into his room around 3:00 p.m. and took a nap, but now R12 only went into his room to nap if R12 noticed that R18 was at dialysis. NA-F stated she thought R12 now napped in his wheelchair in the family room a lot during the daytime. NA-F stated R18 stayed up late and watched television and that R18 liked to sleep with the television on. NA-F stated she thought most evenings the television was left on during the night because that was how R18 liked it. NA-F stated R12 appeared more moody since R18 had become R12's roommate.	F 250		

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On 7/14/16, at 8:37 a.m. R12 was observed seated in his motorized wheelchair in the activity room watching television.

On 7/14/16, at 8:53 a.m. NA-C stated R12 and R18 should never have become roommates. NA-C stated R18 had told R12 that he [R12] did not need to get up at 5:00 a.m. When R18 told R12 this, NA-C stated she had written on a piece of paper that R12 could get up whenever he (R12) wanted to and showed the note to R12. NA-C stated R12 "shook his head yes." However, NA-C stated now R12 stayed in bed until around 7:00 a.m. (two hours later than R12's past preference/routine). NA-C stated R18 had told R12 "if you didn't have to drink so much you wouldn't have to use that urinal so much." NA-C stated R12 had told her that he was ready to pop R18 one. NA-C stated R18 liked to have the television on all the time and NA-C had thought the facility was going to get another television in the room. However, NA-C stated she didn't think that would resolve the roommate problem. NA-C confirmed R12 spent more time out his room since R18 became R12's roommate. NA-C stated R12 used to take a nap in R12's room, but now R12 spent the majority of the time in the family room. NA-C stated she had expressed on two different occasions to the nurse in charge regarding R12 and R18's roommate situation. NA-C stated the first time she brought it up was around 6/23/16. NA-C stated she had seen a change in R12 since R18 became R12's roommate. R12 used to get up and be bubbly and smile and now R12 was more withdrawn and doesn't talk much. NA-C confirmed it was a daily

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occurrence on how R18 treated R12.

On 7/14/16, at 9:35 a.m. NA-E confirmed the verbal interactions from R18 to R12 happened pretty much daily - if it didn't happen then that would be a "good day".

On 7/14/16, at 9:24 a.m. NA-A confirmed the verbal interactions from R18 to R12 happened daily. NA-A stated for example this morning R12 was in the bathroom being assisted with cares by NA-A, and R12 told NA-A that he [R12] was just being smart. NA-A stated R18 hollered "you are always a smart ass." NA-A stated it was stuff like this that happened daily.

On 7/14/16, at 9:53 a.m. R12 was observed seated in his wheelchair on the patio. R12 stated he didn't sleep as well as he used to since R18 became his roommate and he was always tired now. R12 stated he didn't want to talk about R18 anymore.

On 7/14/16, at 10:00 a.m. R12 was interviewed by another surveyor as R12 was an active member of the resident council. R12 confided to this surveyor that the facility was currently working on getting R18 away from R12. R12 stated R18 always yelled at him. R12 stated R18 had the television remote, so when R18 had the television on, R12 just rolled over. R12 stated R18 kept the television on and R12 felt the television caused flashes of light which kept him awake. R12 stated he was just going to keep his mouth shut until he [R12] could be moved.

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R12's Care Conference Summary note dated 7/12/16, indicated under the family/resident comment section that R12 had expressed the following:
- having R18 in R12's room was disturbing
- R18 thought he was the boss
- R18 had the television on at night and R18 complained continuously about R12 making noise in the room and having to use the urinal.

R18's nursing progress note (PN) from 6/15/16, through 7/13/16, lacked documentation regarding R18's unresolved roommate conflict with R12.

R12's PN from 6/15/16, through 7/13/16, lacked documentation regarding R12's unresolved conflict with R18. In addition, R12's medical record lacked documentation of appropriate notification of a roommate change or a follow up assessment of the roommate change.

On 7/14/16, at 10:00 a.m. social worker (SW) confirmed the facility was not at full capacity which was 40 and the current census was 26 residents. SW stated when a resident requested a room change a form was completed and when a resident moved into a room which had a resident already occupying that room, then two forms were to be competed. SW stated one form was completed by the resident requesting or being asked to make the room change and the second form was completed and given to the resident as notification that they would be receiving a new roommate. SW stated if both

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F 250	Continued From page 14 residents agreed to the move, then the move could occur right away. However, if one of the residents hadn't agreed to the move, then there was a seven day adjustment period before the move occurred. SW verified R12 (resident who received a new roommate) had not been provided or signed the Notice Getting A Roommate form, as required. SW stated she had been on vacation when R18 moved and SW was unsure of who followed through on the notification of roommate and/or room changes in the SW's absence. SW confirmed any time there was a conversation regarding a room/roommate change that conversation should be documented in the residents' medical record. SW confirmed R12's medical record lacked documentation regarding notification of R12 getting a roommate. SW verified R12 had told her that he had not been made aware that he would be getting a roommate prior to R18 moving in. SW confirmed R18 had been given notice of the room change on 6/15/16. R18 had refused to sign the notice, so the seven day adjustment period was provided with R18 moving into R12's room on 6/22/16. SW confirmed R12 and R18 did not get along well as roommates. SW stated on 7/12/16, R12 held a care conference which R12's son also attended along with R12. SW stated at the care conference, R12 expressed his displeasure of being roommates with R18. SW stated R12's main concern focused on the television and how R18 liked to have the television on all night long and because the television was positioned directly at the foot of R12's bed the flickering bright lights from the television kept R12 awake at night. In addition, R12 voiced concerns that R18 always wanted to be the boss and that R18 always complained of the noise that R12 made. R12's son also expressed at the care conference	F 250		

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F 250	Continued From page 15 that he was worried about R12 getting enough sleep and felt since R18 had moved in, R12 had not slept as well. SW stated "most definitely" she felt the roommate situation between R12 and R18 had negatively impacted R12's psychosocial well-being, especially after what had been brought up at the care conference. SW stated she expressed to the leadership team at their stand up meetings these last couple of days, her concerns regarding R12 and R18's roommate situation. SW stated she thought they should move R18, however, the leadership team thought R12 should be the one that moved because R12 had requested to move. SW confirmed R12's most recent mood and behavior assessment conducted 5/17/16, identified no mood or behavioral concerns. SW stated she would expect if R12's mood evaluation was completed now, it would be different and show a decline in R12's mood. SW stated overall she felt R12 was less satisfied with R12's current situation. On 7/14/16, at 10:29 a.m. the director of nursing (DON) and administrator confirmed the facility had open resident rooms. The administrator confirmed prior to a resident room change and/or roommate change the appropriate notification was to be provided. The administrator stated she had spoken to both R12 and R18 yesterday (7/13/16) and had offered to move R12 to a temporary room. Then when R12's potential new roommate had been provided proper notice, the facility would again move R12 into that room with the new roommate. The administrator stated R12 declined the temporary move as he didn't want to move twice. R12 opted to wait until proper notice was provided to his potential new roommate and then be relocated. The administrator stated R12	F 250		

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F 250	Continued From page 16 was being moved because R12 had made the request to be moved. The administrator stated potential roommate compatibility was taken into consideration prior to a roommate change and the nurse managers also gathered input from the other staff which included the NAs and the resident and family. Other things considered were the safety with the equipment in the room, if the residents liked the television on, and most definitely sleep routines. The administrator stated the NAs had made her aware today (7/14/16) that R12 and R18 had argued last evening, and last Friday (7/8/16). The administrator stated the NAs had made her aware of the conflicts with the television and that R18 liked to have the television on all the time. The administrator confirmed some tension existed between R12 and R18. The administrator verfied R12's psychosocial well-being had been affected in a negative manner since R18 and R12 became roommates. In addition, the administrator stated she was aware R12 was not comfortable with the current roommate arrangement and was aware that R12 was frustrated. R18's medical record indicated on 7/14/16, at 2:32 p.m. R18 had been moved to another room. On 7/15/16, at 8:53 a.m. R12 stated it had been so nice and quiet in his room last night and it was so nice to be able to get up in the morning when he wanted. Resident Room Relocation policy dated 2/26/15, indicated the social service staff would be involved with any resident room relocations. The resident's social, emotional and cognitive needs would be assessed and considered prior to	F 250		

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F 250	Continued From page 17 relocation of the resident. The impact of room relocation on the resident's psychosocial status would be assessed by the social service staff. The social service staff would work with the interdisciplinary team to consider roommate compatibility to arrive at the most appropriate location for a resident. In addition, a plan would be developed by the social service staff to assure the needs and concerns related to the residents' ability to cope and adjust to the relocation would be addressed by: - A verbal noticed would be provided to the resident or family that was being relocated and this would be documented in the medical record. - Room options would be given when possible. - Resident would be introduced to their new roommate. - The resident and/or their family would be informed that they were receiving a new roommate. - The identified social, emotional, and cognitive need related to the room relocation would be addressed. - A follow up visit would made as needed by the social service staff to aid in the adjustment to the move. - Social service staff would document the resident's response to the move in the medical record. General Guidelines for Transfer of Resident within the Facility policy dated 5/3/16, indicated the residents or their responsible parties would be notified in advance of the transfer. All roommates affected by the transfer would be notified. In addition, how well the resident tolerated the move should be documented.	F 250		

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F 280	Continued From page 18	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the comprehensive care plan to include interventions for pressure ulcer management for 1 of 1 resident (R19) who had acquired a pressure ulcer. Findings include: R19's quarterly Minimum Data Set (MDS) dated 6/6/16, indicated R19 was diagnosed with	F 280	F280 -R19’s comprehensive care plan has been revised to include interventions for pressure ulcer management. -Residents with a change in skin integrity have the potential to be affected if interventions for alterations in skin integrity are not identified and care-planned. -Licensed staff has been educated on updating care plans to reflect current interventions.	8/22/16

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F 280	Continued From page 19 Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all activities of daily living, and was at risk for pressure ulcers and had developed an unstageable pressure ulcer. R19's weekly skin review, dated 6/4/16, indicated R19 had developed and area of eschar to her left heel. R19 was seen by the physician's on 6/6/19 for left heel pressure ulcer, with referral to the wound clinic and cushion device to help relieve pressure. R19's wound clinic visit, 6/9/16, indicated orders for a Mepilex border heel dressing, staff to change dressing every other day and to wear a pressure relieving boot. R19's physician order dated, 7/6/16, indicated dressing change: Apply wet to dry dressing daily to left heel, ok to shower, wound should be washed with soap and water with each dressing change. R19's care plan, print date 7/14/16, lacked revision to include R19's pressure ulcer and interventions related to R19's unstageable left heel pressure ulcer. On 7/14/16, at 3:23 p.m. the director of nursing (DON) stated, R19's care plan should have been revised to include the needed interventions when the pressure ulcer developed.	F 280	-Audits will be completed weekly on residents with pressure ulcers/wounds to ensure care plan is revised with current interventions. Negative findings will be immediately corrected and education provided as needed. Audit results will be reviewed at QAPI for recommendations and to determine continued need for audits. -DNS/Designee is the responsible party. -Corrective action will be completed by August 22, 2016.	

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F 280	Continued From page 20 The facilities Skin Care Protocol, undated, indicated the interdisciplinary plan of care would address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified. The facility procedure guide, Dressing Change, dated 2/4/16, identified care plan documentation guidelines, directing staff to identify the appropriate problem under which to list the dressing change as an approach, list measurable goals, list responsible discipline, with instruction unique to resident, monitoring and observations and preventive measures.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure physician orders were followed for 1 of 1 resident (R19) who required pressure ulcer wound care. Findings include:	F 309	F309 -R19 is receiving wound care per MD orders. UA has been completed, MD has reviewed, and treatment has been completed per MD orders for R5. -All residents have the potential to be affected if MD orders are not followed. -Licensed staff was educated on following	8/22/16

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F 309	Continued From page 21 R19 did not receive pressure ulcer wound care as directed by the physician orders. R19's quarterly Minimum Data Set (MDS) dated 6/6/16, indicated R19 was diagnosed with Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all activities of daily living (ADLs), required extensive assist with positioning, was at risk for pressure ulcers and had developed an unstageable pressure ulcer. R19's physician order report print date 7/14/16, indicated: Apply wet to dry dressing daily to left heel, ok to shower, wound should be washed with soap and water with each dressing change (order date 7/6/16). On 7/14/16, at 3:06 p.m. licensed practical nurse (LPN)-C was observed during R19's left heel pressure ulcer dressing change. LPN-C gloved and removed R19's pressure relief boot and slipper sock from her left foot. A gauze 4 X 4 was removed from the wound. LPN-C measured the left heel pressure ulcer and stated the wound measured 1.5 centimeters (cm) by 1.9 cm. LPN-C removed her gloves and opened two 4 X 4 gauze dressing packages, obtained two pieces of tape, applied saline wound wash to the gauze 4 X 4 and washed the wound using a circular motion. A small amount of debris was observed to be removed from the wound. LPN-C removed her gloves and regloved. LPN-C applied saline to a gauze 4 X 4 and applied it to R19's pressure ulcer wound and applied a dry gauze 4 X 4 over the	F 309	MD orders and following up on orders received. -Audits will be completed 3 times weekly on new orders to insure orders and needed follow up are completed as written. Negative findings will be corrected immediately and education provided as needed. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 309	Continued From page 22 wet 4 X 4 followed by wrapping the left heel with kerlix gauze to secure the dressing. LPN-C removed her gloves and applied R19's slipper sock and pressure relief boot, LPN-C then washed her hands. At 3:19 p.m. LPN-C reviewed R19's order for dressing change, and stated the physician order indicated to wash the wound with soap and water. LPN-C verified she did not follow the physician's order, and should have washed the wound with soap and water prior to applying the dressing. On 7/14/16 at 3:23 p.m. the director of nursing (DON) stated, it was her expectation the nurse follows the physicians order as directed. The dressing change should have been completed as the physician ordered. A facility policy for following/implementing physicians orders was not provided. R5's physician orders were not followed regarding urinary incontinence needs. R5's quarterly MDS dated 4/18/16, indicated R5 was diagnosed with Diabetes, anxiety and disorders of the bladder. The MDS also indicated R5 was cognitively intact, required extensive assist with toileting, and had frequent incontinence of bladder. R5's Urinary Incontinence Care Area Assessment	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23 (CAA) dated 7/13/16, indicated R5 had urinary urgency, required assistance in toileting, had functional incontinence and the overall objective was to minimize risks. R5's Urology visit on 3/25/16, indicated Ditropan (treats overactive bladder) was ineffective, so R5 was to try Vesicare 10 milligrams (mg) (treats overactive bladder). Could consider Botox instillation interavesical. R5's Urology visit on 5/27/16, indicated a recommended physician's order to get a UA (urine test) which would be easier done at the home facility when R5 was in bed, then fax results to physician and if the UA was positive for infection, R5 would be treated for a urinary tract infection (UTI) until clear and then arrange for Botox treatment thereafter. The report indicated R5 was comfortable with that approach would like to proceed with further management. R5's clinical record lacked indication the UA was completed and results faxed to the physician, or any further follow up related to R5's urology visit. On 7/13/16, at 1:15 p.m. nursing assistant (NA)-A stated R5 needed to go to the bathroom a lot, sometimes 15-30 times in an 8 hour shift. NA-A stated she had assisted R5 to the commode 12 times on my shift so far. On 7/14/16, at 8:59 a.m. R5 stated the girls came and helped her but sometimes she cannot wait	F 309		

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	245323	A. BUILDING ______ B. WING ______	07/15/2016

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F 309	Continued From page 24 until they get here and my urine just comes out. R5 stated she was going to see a specialist to see what they can do for her urinary frequency as different medicine had been attempted which R5 thought is had helped. R5 also stated the physician was going to do something else, but she didn't know when. On 7/15/16, at 8:45 a.m. registered nurse (RN)-A stated she did not know who was responsible for following up on physician orders and did not know why anything wasn't done about R5's urology follow up. On 7/15/16, at 10:08 a.m. the facilities clinical director consultant stated she had reviewed R5's medical record and confirmed there was no documentation which indicated labs, follow up, or an attempt to schedule the Botox appointment was completed as directed by R5's physician's order on 5/27/16 urology visit. On 7/15/16, at 1:19 p.m. the director of nursing (DON) verified R5's physician's orders should have been addressed and followed up on. The DON stated it was her expectation that all orders be followed. A facility policy for following/implementing physician's orders was not provided.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		8/22/16

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F 329	Continued From page 25 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facilty failed to act upon the consulting pharmacist's recommendations for 1 of 5 residents (R18) who had ongoing consulting pharmacist recommendations which were not acted upon, as required. Finding include: R18's Diagnosis Report dated 7/14/16, identified	F 329	F329 -Pharmacy recommendations for R18 have been reviewed and addressed by the MD responsible. -All residents have the potential to be affected if pharmacy recommendations are not addressed by MD. -ADNS has been educated on following up on pharmacy recommendations with the responsible MD. -Pharmacy recommendations will be reviewed twice monthly to ensure	

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F 329	Continued From page 26 R18's diagnoses as gastro-esophageal reflux disease (GERD-heart burn), obstructive sleep apnea (a sleep disorder when breathing repeatedly stops and starts which occurs when the throat muscles relaxes), end stage renal disease, dependent on renal dialysis, diabetes, heart failure, hypertension and major depression. R18's admission Minimum Data Set (MDS) dated 5/12/16, indicated R18 was on dialysis and received a daily dose of insulin and an antidepressant. R18's Psychotropic Drug Use Care Area Assessment (CAA) dated 5/20/16, indicated R18 had not been taking a sedative/hypnotic. R18's Order Summary Report dated 7/14/16, directed staff to administer: - Pantoprazole Sodium delayed release 40 milligrams (mg) twice a day (medication usually used short term to treat GERD and excessive acid production) - temazepam 15 mg every evening as needed (medication used to treat insomnia) R18's Pharmacy Review notes dated 5/16/16, 6/13/16, and 7/11/16, repeatedly indicated that the consulting pharmacist (CP) had recommended a gradual dose reduction (GDR) be considered for pantoprazole. In addition, consideration be taken for a GDR for temazepam if not being used.	F 329	recommendations have been addressed by MD responsible. Negative findings will be addressed with MD responsible immediately. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 329	Continued From page 27 R18's medication administration records (MAR) for May, June and July 2016, indicated R18 had not taken the temazepam at all and had on occasion refused a dose of R18's scheduled pantoprazole. R18's provider progress note dated 7/14/16, lacked acknowledgement of the CP's above noted recommendations. On 7/15/16, at 8:37 a.m. licensed practical nurse (LPN)-B confirmed R18 had temazepam ordered when needed at bedtime for sleep, however, R18 had not been administered the temazepam for the month of July. On 7/15/16, at 1:42 p.m. director of nursing (DON) confirmed R18 had current orders for and had received pantoprazole delayed release (DR) 40 mg twice a day. In addition, the DON confirmed R18 had temazepam 15 mg ordered as needed at night and had not taken the temazepam since the medication had been ordered (5/12/16). The DON also confirmed the above noted CP recommendations dated 5/16/16, 6/13/16, and 7/11/16, regarding the considerations for GDR's for both R18's temazepam and pantoprazole and stated it was her expectation that these recommendations be followed up upon in a timely manner. The assistant director of nursing (ADON) stated an e-mail was sent each month by the CP which included the CP's recommendations for each resident in which she placed a copy of these e-mails into the physician's mailbox for the physician's review when the physician came for	F 329		

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F 329	Continued From page 28	F 329		

rounds the next time. The ADON confirmed she never reviewed the CP's monthly pharmacy review note in the computer which included the CP's monthly recommendations. The ADON confirmed she had rounded with the physician the day prior (7/14/16), however, was unsure if the physician had received R18's recommendations from the pharmacists monthly drug regime review for May, June or July 2016.

On 7/15/16, at 2:56 p.m. the CP confirmed he documented each month in the medical record his recommendations for each resident based on the CP's monthly resident medication regime review. In addition, the CP stated he sent an e-mail each month to the ADON with the same recommendations he had articulated in the pharmacy review note which was already available in the resident's medical record. The CP verified he had made recommendations for GDR's for R18's temazepam and pantoprazole for the last three months and stated it would be his expectation that these recommendations be brought to the physician's attention and acted upon.

Consultant Pharmacist Services Provider Requirements policy dated 5/12, indicated the CP would review the medication regimen of each resident at least monthly and this review would be documented in the resident's medical record or a readily retrievable format. The CP would communicate monthly to the responsible prescriber and the facility leadership recommendations for changes in medication therapy.

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F 356	Continued From page 29	F 356		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months, as	F 356	F356 -Daily posting of staff hours is being retained to meet the required 18 month	8/22/16

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F 356	Continued From page 30 required. This had the potential to affect all residents, family or visitors who wished to review this information. Findings include: On 7/14/16, at 2:00 p.m. the facility posted daily nurse staffing data sheets from 6/27/16, to 7/14/16, were reviewed. The facility daily nurse staffing data sheets for 6/28/16, 6/29/16, 7/1/16, 7/2/16, 7/3/16, 7/4/16, and 7/8/16, were not missing. Further review of the facility's daily nurse staffing data sheets for 2016, indicated the following staff data sheets were missing: 1/8/16, 1/9/16, 1/10/16, 1/15/16, 2/6/16, 2/7/16, 2/14/16, 2/20/16, 3/6/16, 3/17/16, 3/27/16, 5/27/16, 6/1/16, 6/2/16, 6/3/16, 6/4/16, 6/5/16, 6/6/16, 6/7/16, and 6/30/16. On 7/15/16, at 11:45 a.m. the administrator stated if the daily nurse staffing data sheets were not in the folder, the facility did not have them. A policy on daily nurse staffing was requested however, no policy was received.	F 356	retention. -All residents and visitors have the potential to be affected if daily posting of staff hours is not maintained and available for review. -Education has been provided to medical records on requirement to retain 18 months of daily posting of staff hours. -Audit will be completed twice weekly to ensure daily posting of staff hours is maintained. Negative findings will be corrected and education provided as necessary. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -ED/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days	F 387		8/22/16

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F 387	Continued From page 31 thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R18) who was reviewed for timely physician visits had received a physician visit every 30 days for the first three months. Findings include: R18's admission Minimum Data Set (MDS) dated 5/12/16, indicated R18 had been admitted to the facility on 5/12/16, with diagnoses which included anemia, coronary artery disease, heart failure, hypertension, gastroesophageal reflux, end stage renal disease, diabetes, and depression. R18's clinical record indicated R18 had been evaluated by a physician's assistant (PA)-A on 5/18/16, went to a follow up appointment with a surgeon on 6/28/16, and was evaluated by R18's primary medical doctor (MD)-A on 7/14/16. Physician Visit Control Log for 2016, indicated R18 was scheduled to be seen by MD-A on 5/17/16, 6/16/16, and 7/14/16.	F 387	F387 -R18 is receiving timely MD visits at intervals per regulation. -All residents have the potential to be affected if MD visits are not completed at intervals per regulation. -ADNS has been educated on requirement for timely MD visits to meet regulatory guidelines. -Audits will be completed twice monthly to review that residents are receiving MD visits timely. Negative findings will be addressed immediately. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 387	Continued From page 32 R18's progress note dated 6/30/16, indicated MD-A did not see R18 when MD-A rounded at the facility. On 7/15/16, at 10:21 a.m. licensed practical nurse (LPN)-A stated she was unsure why MD-A missed evaluating R18 in June. LPN-A confirmed she had contacted R18's primary clinic and the clinic verified R18 had not been seen by MD-A, on 6/16/16, as scheduled. On 7/15/16, at 2:05 p.m. director of nursing (DON) and assistant director of nursing (ADON) confirmed R18 should have been seen by a physician once a month for the first three months following admission to the facility. After the 30, 60, and 90 day evaluations by a physician, then a physician could evaluate R18 every other month. The DON and ADON confirmed R18's 60 day visit should have occurred by 6/21/16. A facility policy on physician visit schedules was not provided.	F 387		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if	F 411		8/22/16

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F 411	Continued From page 33 necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dental services for 1 of 3 residents (R14) reviewed for dental services. Findings include: R14's undated Face Sheet indicated R14 was diagnosed with multiple sclerosis (MS), major depression and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated 5/16/16, indicated R14 had not issues with oral/dental status and R14 required extensive assistance for oral cares and was non-ambulatory. R14's Activities of Daily Living Care Area Assessment dated 12/8/15, indicated R14 required extensive assist with dressing secondary to limited range of motion, poor balance, and generalized weakness as related to MS and a poor memory. R14's care plan dated 5/13/16, directed staff to assist with oral care two times a day and refer to dental services as needed. On 7/12/16, at 9:15 a.m. R14 was observed to have multiple missing, broken, and loose teeth.	F 411	F411 -R14 has had dental issues addressed. -All residents have the potential to be affected if dental needs are not addressed. -Licensed staff has been educated on providing and following up on dental recommendations. -Audits will be completed on 4 residents weekly to ensure dental needs are addressed. Dental referrals will be completed if dental needs are identified. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 411	Continued From page 34 R14 stated she was losing her teeth. R14 stated the staff would not help her with dental visits because she had MS, was on UCARE insurance, and added "I am not on welfare." R14's faxed order sheet dated 2/17/16, indicated R14 had been complaining of pain and a dental appointment had been made for 2/23/16. In addition, the faxed order sheet queried the doctor and asked if R14 required antibiotics, R14 was on Tylenol and Tramadol PRN (as needed) for pain, and R14's family was wondering about an antibiotic for oral pain, until R14's appointment on 2/23/16. The physician response dated 2/18/16, directed staff to "hold off on antibiotic for now, call if worse." No other information on R14's dental issue was noted in the medical record regarding dental appointments or recommendations. The 2/19/2016, Quarterly Interdisciplinary Resident Review form, indicated R14 had no "broken, loose, or carious teeth." R14's nurse progress note dated 6/8/16, indicated R14 had a broken tooth on the upper right side of her mouth. further documentation read: "Background: R14 had some dental caries, states that she has tried to obtain dental care in the past and has been rejected by clinics due to type of insurance she has." Assessment: Upper right pre-molar appeared to have splintered. R14 denied any pain or hot/cold sensitivities at that time. No swelling, bleeding, or exposed root visible. Response: Recommend attempt to find dental care for resident.	F 411		

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F 411	Continued From page 35 No additional information on R14's dental issue was noted in the medical record. On 7/13/16, at 12:45 p.m. licensed practical nurse (LPN)-B stated R14 was seen by a dentist 2/23/16, and was referred to Northern Dental in Bemidji who could not pull the teeth. At that time, Northern Dental referred R14 to an oral surgeon in Fargo. LPN-B stated that facility wanted $1000.00 in which R14's daughter was notified. At the time of the appointment, R14 utilized UCARE insurance. However, R14's medical record lacked documentation regarding the 2/23/16, Northern Dental visit, the recommendation for follow up care with an oral surgeon in Fargo or that R14's daughter had been informed of R14's dental service needs/cost of service. On 7/14/16, at 10:50 a.m. during a telephone interview, R14's daughters confirmed an appointment had been made for R14 to go to Fargo and stated she had advised the facility that her mother could not make the trip due to R14's current physical/medical status because it was too far for her mother to travel. R14 also stated she was told by the facility that there was no local place that would accept R14's insurance unless R14 went to Fargo. R14's daughter stated this was in Feb or March, and nothing had happened with her mother's teeth since then. R14's daughter stated her mother had an infection in her mouth because of the needed teeth extractions and it was absolutely uncalled for that nobody would take care of her mother's teeth. On 7/14/16, at 2:45 p.m. R14 stated she had pain in her mouth all the time and especially had discomfort when she chewed her food. R14	F 411		

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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 411	Continued From page 36 stated she had one tooth in her mouth that she had to periodically push down so it stayed in her mouth. R14 stated again that she was under UCARE insurance which was not welfare, and felt someone should be able to take care of her dental needs. On 7/15/16, at 8:35 a.m. the director of nursing (DON) and assistant director of nursing (ADON) were interviewed regarding R14's dental needs. Review of the medical record with the DON, indicated on 2/18/16, R14 was given Tramadol 50 milligrams (mg) for oral pain which was effective. The DON verified the doctor was contacted regarding starting on an antibiotic on 2/18/16, due to R14's complaints of oral pain. The DON and ADON verified staff had not documented in the medical record regarding R14's dental appointments. The DON verified R14's dental needs were not met and the facility would be working on getting her an appropriate appointment to see the dentist for her teeth issues. The DON also stated the staff would be trained on documenting dental appointments in each residents' medical record. A policy on Dental Services was requested, however no policy was received.	F 411		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		8/22/16

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F 425	Continued From page 37 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a hypnotic medication was available as prescribed for 1 of 1 resident (R18) who had an as needed (PRN) hypnotic prescribed. Findings include: R18's Diagnosis Report dated 7/14/16, identified R18's diagnoses as gastro-esophageal reflux disease (GERD-heart burn), obstructive sleep apnea (a sleep disorder when breathing repeatedly stops and starts), end stage renal disease, dependent on renal dialysis, diabetes, heart failure, and major depression. R18's admission Minimum Data Set (MDS) dated 5/12/16, indicated R18 was on dialysis and	F 425	F425 -All ordered medications have been obtained for R18. R18 has had a sleep assessment completed and reviewed by MD. -All residents have the potential to be affected if ordered medications are not available. -Licensed staff has been educated on procedure for obtaining medications as ordered and obtaining required prescription for controlled medications when ordered. -Audits will be completed twice weekly on medication administration record for medications not available. Pharmacy and MD will be notified immediately for any negative findings and education provided as needed. Audit results will be reviewed at QAPI for recommendations and need for continued audits.	

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F 425	Continued From page 38 received a daily dose of insulin and an antidepressant. R18's Psychotropic Drug Use Care Area Assessment (CAA) dated 5/20/16, indicated R18 had not been taking a sedative/hypnotic. R18's Order Summary Report dated 7/14/16, directed staff to administer temazepam 15 milligrams (mg) every evening as needed (medication used to treat insomnia). R18's temazepam had initially been ordered on 5/12/16. R18's Pharmacy Review notes dated 5/16/16, 6/13/16, and 7/11/16, repeatedly indicated the consulting pharmacist (CP) had recommended a gradual dose reduction (GDR) be considered for temazepam as R18 had not been using the medication. R18's medication administration records (MAR) for May, June and July 2016, indicated R18 had not been administered the temazepam 15 mg at bedtime as ordered. On 7/15/16, at 8:37 a.m. licensed practical nurse (LPN)-B confirmed R18 had temazepam ordered when needed at bedtime for sleep, however, R18 had not been administered the temazepam for the month of July. LPN-B commented that she didn't know if the facility even had the medication in the medication cart to give R18, if he had requested. LPN-B thought there may have been some evenings where R18 would have used the	F 425	-DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 425	Continued From page 39 medication. On 7/15/16, at 2:06 p.m. assistant director of nursing (ADON) verified the facility did not have temazepam available for R18. Both the director of nursing (DON) and ADON confirmed it was the expectation that the facility have all of R18's ordered medications available for R18. The DON confirmed the pharmacy in town filled the residents' medications. The ADON was unable to articulate a reason why R18's temazepam which had been ordered on 5/12/16, was still unavailable to R18 today (7/15/16). On 7/15/16, at 2:56 p.m. consulting pharmacist (CP) stated he was unaware that R18's temazepam had not been made available to R18. CP confirmed all ordered medications, including the temazepam, should have been filled and made available to R18. On 7/15/16, at 3:30 p.m. pharmacy technician (PT)-A (from the local pharmacy) verified their pharmacy supplied the medications for the facility. PT-A confirmed R18's prescription for temazepam which had been ordered on 5/12/16, had not been filled due to the pharmacy required a hard copy of the prescription or an electronically ordered prescription for the temazepam. PT-A confirmed the pharmacy had not received from the facility either the hard copy prescription or the electronically signed prescription for R18's temazepam 15 mg. On 7/15/16, at 3:59 p.m. The ADON stated R18	F 425		

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F 425	Continued From page 40 was admitted to the facility from the hospital and usually the hospital physicians' electronically submitted their prescriptions or sent a hard copy prescription with the resident. When the facility obtained the hard copy prescription, this would then be faxed to the local pharmacy and when the pharmacy brought the medications they would be given the hard copy prescription. LPN-B confirmed when the pharmacy delivered medications to the facility, the medication nurse signed off that they had received the medications, however, the facility had no medication reconciliation process in place to determine if all medications had been received as ordered. The ADON was unable to explain why R18's temazepam order had not been followed through. On 7/15/16, at 6:00 p.m. nurse consultant (NC) confirmed R18 had not had a sleep pattern assessment completed. Provider Pharmacy Requirements policy dated 5/12, indicated regular and reliable pharmaceutical services would be available to provide residents with prescription and nonprescription medications.	F 425		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		8/22/16

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F 431	Continued From page 41 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the proper monitoring and security for 5 of 5 emergency medication kits, one which contained narcotic medication. This had the potential to affect all 26 residents residing in the facility who could have potentially required medications/narcotics from the emergency kits. Findings include:	F 431	F431 -E kits have been removed from the facility. All controlled medications remaining in the facility have been accounted for. -All residents receiving medications have the potential to be affected if expired medications are administered. -Licensed staff has been educated on checking expiration dates, monitoring/security of controlled medications, accountability for controlled	

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F 431	Continued From page 42 On 7/15/16, at 1:31 p.m. during the medication storage tour of the main medication room with licensed practical nurse (LPN)-A, five emergency medication (ekit) storage boxes were observed. These ekit storage boxes were composed of a grey plastic with a clear plastic lid and measured appropximately 18 inches by 24 inches, and three inches in depth. There were labels on the lids of four of the five ekits which identified the contents of each individual ekit (one of the ekits lacked a label). Three of the ekits, one which contained narcotic medications were found stored on top of an automated medication dispensing machine. The other two ekits were in a cabinet with a padlock on the door handles. LPN-A stated she was unaware of the facility's policy for medication storage and monitoring of the ekits which included the narcotic ekit. LPN-A verified the pharmacy which initially had provided the ekits was no longer providing pharmacy services to the facility. LPN-A stated she had recently accessed the ekits on this past Monday, as a resident had an order for an antibiotic. The ekits had not contained the antibiotic the resident required, so LPN-A contacted the pharmacy which currently provided the facility with it's medications. LPN-A verified she would have used the medication from the ekit if it had been available. On 7/15/16, at 2:35 p.m. the assistant director of nursing (ADON) stated she did not know anything about the ekits. The ADON further stated she did not know if anyone routinely checked the medications for expiration dates, checked the security of the seals on the ekits, or if there were logs used to document the usage of the medications in the ekits. The ADON stated the	F 431	medications, and reconciliation of controlled medications every shift. -Random audits will be performed on medication carts weekly to check for expired and/or undated medications. Negative findings will be corrected immediately and education provided as needed. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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ekits were there when she started which was about two years ago.

The contents of the ekits were as followed and verified by the director of nursing (DON):

Injectable Emergency Supply Kit -

-Adrenalin (Epinephrine) 1:1000 1 milligrams (mg)(used in life-threatening-allergic reactions) quantity (QTY) 2
-Benadryl 50 mg (antihistamine) QTY 4
-Decadron 4 mg (corticosteriod) QTY 2
-Glucagon Emergency Kit-(controls blood sugar levels) QTY 2
-Haldol 5 mg (antipsychotic) QTY 2
-Heparin-5000 units (blood thinner) QTY 10
-Lasix-10 mg (diuretic) QTY 4
-Lovenox 40 mg (anticoagulant) QTY 2
-Lovenox 100 mg (anticoagulant) QTY 2
-Narcan 0.4 mg (opiate antidote) QTY 2
-Reglan 5mg (gastroesophogeal reflux) QTY 4
-Solu-Medrol 125 mg (corticosteriod) QTY 2
-Visteril 25 mg (antihistamine) QTY 2
-Vitamin K 10 mg (anticoagulant) QTY 2
-Zofran 2 mg (antiemetic) QTY 6

The director of nursing (DON) verified the ekit had seals on the the corners of the kit, which lacked identification numbers and the left seal was broken. The DON verified the medication count was accurate and no medications were expired.

The Oral Emergency Supply kit - seal #368210/46011 contained:

-Amoxil 250 mg (antibiotic) QTY 10

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F 431	Continued From page 44 -Augmentin 500 mg (antibiotic) QTY 10 -Augmentin 875 mg (antibiotic) QTY 10 -Avelox 400 mg (antibiotic) QTY 4 -Bactrim 800 mg (antibiotic) QTY 10 -Catapres 0.1 mg (antihypertensions) QTY 2 -Ceftin 250 mg (antibiotic) QTY 10 -Cipro 250 mg (antibiotic) QTY 10 -Compazine suppository 25 mg (antiemetic) QTY 4 -Coumadin 1 mg (anticoagulant) QTY 1 -Instaglucose 31 grams (gm) (boosts glucose) QTY 2 -Kayexalate 15 gm (treats hyperkalemia) QTY 2 -Keflex 250 mg (antibiotic) QTY 20 -Lasix 20 mg (diuretic) QTY 10 -Levaquin 250 mg (antibiotic) QTY 10 -Macrobid 100 mg (antibiotic) QTY 10 -Nitroquick 0.4 mg (nitrate) QTY 25 -Proventil/Ventolin 0.083% (nebulizer solution) QTY 6 -Vitamin K 5 mg (used for blood coagulation) QTY 2 -Zithromax 250 mg (antibiotic) QTY 6 The DON verified the left seal on the ekit was broken, the medication count was not accurate, four doses of the Proventil/Ventolin were not accounted for and the Kayexalate was not in the kit, and no medications in the ekit were expired. The Oral Emergency Supply kit Box #0-36, contained seals with no numbers on them. Contents included: -Amoxil 250 mg (antibiotic) QTY 10 (expired 11/30/15) -Augmentin 500 mg (antibiotic) QTY 10 (expired 10/18/15)	F 431		

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F 431	Continued From page 45 -Augmentin 875 mg (antibiotic) QTY 10 (expired 8/6/14) -Avelox 400 mg (antibiotic) QTY 4 (expired 3/2015) -Bactrim 800 mg (antibiotic) QTY 10 (expired 4/2015) -Catapres 0.1 mg (antihypertensions) QTY 2 -Ceftin 250 mg (antibiotic) QTY 10 (expired 12/16/14) -Cipro 250 mg (antibiotic) QTY 10 (expired 8/30/14) -Compazine suppository 25 mg (antiemetic) QTY 4 -Coumadin 1 mg (anticoagulant) QTY 20 (expired 1/31/15) -Instaglucose 31 grams (gm) (boosts glucose) QTY 2 -Kayexalate 15 gm (treats hyperkalemia) QTY 2 -Keflex 250 mg (antibiotic) QTY 10 (expired 8/3/14) -Lasix 20 mg (diuretic) QTY 10 (expired 8/2014) -Levaquin 250 mg (antibiotic) QTY 10 (expired 9/2014) -Macrobid 100 mg (antibiotic) QTY 10 (expired 8/2014) -Nitroquick 0.4 mg (nitrate) QTY 25 (expired 6/2015) -Proventil/Ventolin 0.083% (nebulizer solution) QTY 6 -Vitamin K 5 mg (used for blood coagulation) QTY 2 (expired 10/11/14) -Zithromax 250 mg (antibiotic) QTY 6 (expired 10/11/14) The DON verified all of the medication with the exception of the Catapres, Compazine, Instaglucose and Kayexalate had expired dates, in addition, the medication count was not accurate. The inventory list taped to the top of the	F 431		

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ekit, indicated there should have been 10 doses of the Macrobid 100 mg and the ekit only contained nine doses (one dose of Macrobid unaccounted for).

Medication Ekit seal tags #368213/368279 did not have a contents list on the lid. The ekit contained:

-Benadryl 50 mg (antihistamine) QTY 4 vials
-Decadron 4 mg (corticosteriod) QTY 2 vials
-Adrenalin (Epinephrine) 1:1000 1 milligrams (mg)(used in life-threatening-allergic reactions) QTY 2 vials
-Haldol 5 mg (antipsychotic) QTY 2 vials
-Heparin-5000 units (blood thinner) QTY 9 vials
-Lasix-10 mg (diuretic) QTY 4 vials
-Narcan 0.4 mg (opiate antidote) QTY 2 vials
-Reglan 5mg (gastroesophogeal reflux) QTY 4 vials
-Solu-Medrol 125 mg (corticosteriod) QTY 2 vials
-Visteril 25 mg (antihistamine) QTY 2 vials (expired 5/2016)
-Vitamin K 10 mg (anticoagulant) QTY 2 vials (expired 5/1/16)
-Zofran 2 mg (antiemetic) QTY 6 vials
-Lovenox 40 mg (anticoagulant) QTY 2 syringes
-Lovenox 100 mg (anticoagulant) QTY 2 syringes
-Glucagon Emergency Kit-(controls blood sugar levels) QTY 2 kits

The DON verified the ekit lacked a pharmacy content label on the cover, therefore they were not able to verify if the medication count was accurate. In adidtion, verified the ekit contained two expired medications, the Visteril 25 mg and Vitamin K 10 mg.

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The Narcotic Emergency Supply ekit- seal # 429430/429436 contents included:

-Ativan 0.5mg QTY 6
-Ativan 2 mg injection QTY 2
-Dilaudid 2 mg QTY 6
-Morphine sulfate injection 10 mg QTY 4
-Morphine sulfate suppository 5 mg. QTY 4
-Oxycodone 5mg QTY 6
-Percocet 5/325 mg QTY 6
-Morphine sulfate oral solution 10 mg QTY 6
-Tylenol # 3 300mg/30 mg QTY 6
-Valium Injection 5mg QTY 2
-Vicodin tablets 5/500 mg QTY 6

The DON verified the narcotic ekit contained narcotic medications and the narcotic medication count was inaccurate. Medications which were unaccounted for included: (with discrepancies included:)

-Vicodin tablets 5/500 mg QTY 6
-Valium Injection 5mg QTY 2
-Morphine sulfate oral solution 10 mg QTY 6
-Morphine sulfate suppository 5 mg. QTY 4
-Ativan 2 mg injection QTY 2

The DON verified the above noted medications were unaccounted for.

On 7/15/16, at 2:40 p.m. the DON stated she was unaware that the ekits existed, or that staff had attempted to utilize the medications out of the ekits. The DON verified the nurses should have been routinely ensuring the ekits were secured with the required seals, were stored appropriately to ensure the security of the medications, and the

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F 431	Continued From page 48 medications should have been monitored for expiration dates and reconciled. The DON stated the ekit storage system and lack of monitoring was a concern and she would expect staff to be monitoring them daily, and the narcotic medications should have been double locked. On 7/15/16, at 2:58: p.m. the consulting pharmacist (CP) stated he checked the facility's medication storage room on a quarterly basis. The CP stated he would have included any recommendations regarding ekits monitoring and storage on his report to the facility, but does not recall making any recommendations for the ekits. The CP verified proper monitoring and storage of ekits was something he looked for, including use of ekit medications and expiration dates of the medications. The CP stated he would expect the facility to monitor the use of ekit medications and the seals on a daily basis, especially the controlled (narcotic) medications. The CP stated he was unaware the facility's medication storage room contained these five ekits of medication. CP confirmed he had missed this and it would have been something that he should have included in his review of the medication storage process at the facility. Emergency Pharmacy Service and Emergency Kits policy, dated 5/12, indicated the emergency supply was maintained at a designated area, along with a list of supply contents and expirations dates, the nurse records the medication use from the emergency kit on the medication form and flags the kit with a color-coded lock to indicate need for replacement. The kits are monitored/inventoried	F 431		

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	245323	A. BUILDING ______ B. WING ______	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 49 by the consultant pharmacist/provider pharmacy at least every 30 days for completeness and expiration dating of the contents. Accountability for controlled substances stored in the emergency kit is maintained as follows: a perpetual inventory system is used with a separate sheet or a bound book with numbered pages for each individual medication in the kit. Each dose given and all replacement doses received from the pharmacy are entered on the appropriate inventory sheet with the "Amount Remaining" adjusted accordingly. The incoming and outgoing nurses verified the inventory of controlled substances at each change of shift or exchange of keys.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		8/22/16

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F 441	Continued From page 50 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene was implemented for 1 of 1 resident (R19) observed for wound care. In addition, the facility failed to ensure wheelchair cushions were properly covered for 2 of 2 residents (R2, R28) to ensure cleanable and sanitary surfaces were provided. Findings Include: R19's wound care was observed and the facility failed to implement proper hand hygiene during the provision of the wound care.	F 441	F441 -Staff are utilizing proper hand washing between glove changes for R19. R2 and R28 have been provided with washable covers for their wheelchair cushions. -All residents have the potential to be affected if infection control measures are not followed. -Nursing staff has been educated on infection control measures with emphasis on hand hygiene related to glove changes and maintaining cleanable, washable surfaces for resident equipment. -Audits of proper hand hygiene during dressing changes will be completed twice weekly. Audits of resident equipment will be completed weekly to ensure surfaces are cleanable. Negative findings will be	

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F 441	Continued From page 51 R19's quarterly Minimum Data Set (MDS) dated 6/6/16, indicated R19 was diagnosed with Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all activities of daily living (ADLs), required extensive assist with positioning, was at risk for pressure ulcers and had developed an unstageable pressure ulcer. R19's physician order report print date 7/14/16, indicated: Apply wet to dry dressing daily to left heel, ok to shower, wound should be washed with soap and water with each dressing change (order date 7/6/16). On 7/14/16, at 3:06 p.m. licensed practical nurse (LPN)-C was observed performing R19's left heel pressure ulcer dressing change. LPN-C gloved and removed R19's pressure relief boot and slipper sock from her left foot. A gauze 4 X 4 was removed from the wound. LPN-C measured the left heel pressure ulcer and stated the wound measured 1.5 centimeters (cm) by 1.9 cm. LPN-C removed her gloves and opened two 4 X 4 gauze dressing packages, obtained two pieces of tape, applied saline wound wash to the gauze 4 X 4 and washed the wound using a circular motion. A small amount of debris was observed to be removed from the wound. LPN-C removed her gloves and regloved. LPN-C applied saline to a gauze 4 X 4 and applied it to R19's pressure ulcer wound and applied a dry gauze 4 X 4 over the wet 4 X 4 followed by wrapping the left heel with kerlix gauze to secure the dressing. LPN-C removed her gloves and applied R19's slipper sock and pressure relief boot, LPN-C then washed her hands.	F 441	corrected immediately with education provided as needed. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 441	Continued From page 52	F 441		

-At 3:19 p.m. LPN-C verified she did not wash her hands after removing her gloves throughout the provision of wound dressing change treatment and should have. LPN-S verified she had training on gloving and the dressing change process.

On 7/14/16 at 3:23 p.m. the director of nursing (DON) stated, it was her expectation for the nurse to wash her hands after removing gloves and prior to donning clean gloves during a dressing change. The DON stated the facility would make sure training was provided to all staff who perform dressing changes to make sure the procedure and policy was followed.

The facility policy, Handwashing/Hand Hygiene, dated 2/4/16, indicated the facility considered hand hygiene the primary means to prevent the spread of infections and all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections.

R2 and R19's wheelchair positioning cushions lacked cushion covers to ensure sanitary and cleanable surfaces.

R2's diagnosis list dated 7/15/16, identified diagnosis of edema, muscle weakness dermatitis, overactive bladder and epilepsy.

R2's quarterly minimum data set (MDS) dated 6/2/16, indicated R2 was totally dependent on staff for transfers to wheelchair, was at risk for

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F 441	Continued From page 53	F 441		

pressure ulcers, was frequently incontinent of bowel and bladder and utilized a pressure reducing device for bed and chairs.

On 7/13/16, at 12:30 p.m. and during intermittent observations throughout the survey from approximately 8:00 a.m. to 4:30 p.m. on 7/14/16, and 7/15/16, R2's was observed seated in a wheelchair with an uncovered, yellow, foam pummel shaped seat cushion. The foam was uncleanable.

R28's quarterly MDS dated 4/27/16, identified diagnosis of indicated R28 required extensive assist with transferring and position between surfaces- bed-wheelchair. The MDS further indicated, R28 was at risk for pressure ulcers and utilized a pressure reducing device on his bed and chair.

R28's progress note dated 7/9/16, indicated R28 utilized a wheelchair for mobility which was propelled by staff.

On 7/12/16, at 1:21 p.m. R28 was observed seated in the wheelchair in own room. The wheelchair cushion was an uncovered, gray foam

On 7/13/16, at 12:31 p.m. R28 was observed in the dining room, seated in the wheelchair on top of a gray, uncovered, foam cushion.

On 7/14/16, at 11:00 a.m. R28 was observed in the hallway, seated in the wheelchair on top of a gray, uncovered foam cushion.

On 7/15/16, at 9:44 a.m. R28 was observed in

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F 441	Continued From page 54 own room seated in the wheelchair on top of a gray, uncovered foam cushion. During a tour on 7/15/16, at 9:59 a.m. the maintenance director (MD) observed R2's cushion which a white bath towel was placed on top of the yellow foam cushion. The MD verified the cushion should have a non-permeable cushion cover on it. The MD also observed R28's wheelchair cushion and verified the grey foam cushion should also be covered. The MD stated housekeeping cleaned the wheelchairs and if the cushions became dirty, they were removed to be cleaned. The MD stated the covers should have been replaced right away prior to use. The MD verified the lack of cushion covers was an infection control concern as the foam cushions were not cleanable surfaces. The MD stated he did not believe the facility had a policy regarding cleaning cushion covers. On 7/15/16, at 1:15 p.m. the DON verified the wheelchair pressure relieving cushions should have covers on them at all times. The DON also confirmed with the lack of cleanability, the uncovered cushions would be an infection control issue.	F 441		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced	F 504		8/22/16

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F 504	Continued From page 55 by: Based on interview and document review, the facility failed to ensure physician orders for a urinalysis was acted upon for 1 of 1 resident (R5) who had an order for a urinalysis lab test for which was not completed. Findings include: R5's quarterly MDS dated 4/18/16, indicated R5 was diagnosed with Diabetes, anxiety and disorders of the bladder. The MDS also indicated R5 was cognitively intact, required extensive assist with toileting, and had frequent incontinence of bladder. R5's Urinary Incontinence Care Area Assessment (CAA) dated 7/13/16, indicated R5 had urinary urgency, required assistance in toileting, had functional incontinence and the overall objective was to minimize risks. R5's Urology visit on 3/25/16, indicated Ditropan (treats overactive bladder) was ineffective, so R5 was to try Vesicare 10 milligrams (mg) (treats overactive bladder). Could consider Botox instillation interavesical. R5's Urology visit on 5/27/16, indicated a recommended physician's order to get a UA (urine test) which would be easier done at the home facility when R5 was in bed, then fax results to physician and if the UA was positive for infection, R5 would be treated for a urinary tract	F 504	F504 -UA has been obtained as ordered for R5. MD has reviewed results and subsequent orders are being completed. -All residents have the potential to be affected if labs are not completed as ordered and/or follow up is not completed as ordered. -Licensed staff has been educated on following up on MD orders. -Audits will be completed 3 times weekly on new orders to insure orders and needed follow up are completed as written. Negative findings will be corrected immediately and education provided as needed. Audit results will be reviewed at QAPI for recommendations and need for continued audits. -DNS/Designee is the responsible party. - Corrective action will be completed by August 22, 2016.	

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F 504	Continued From page 56	F 504		

infection (UTI) until clear and then arrange for Botox treatment thereafter. The report indicated R5 was comfortable with that approach would like to proceed with further management.

R5's clinical record lacked indication the UA was completed and results faxed to the physician, or any further follow up related to R5's urology visit.

On 7/13/16, at 1:15 p.m. nursing assistant (NA)-A stated R5 needed to go to the bathroom a lot, sometimes 15-30 times in an 8 hour shift. NA-A stated she had assisted R5 to the commode 12 times on my shift so far.

On 7/14/16, at 8:59 a.m. R5 stated the girls came and helped her but sometimes she cannot wait until they get here and my urine just comes out. R5 stated she was going to see a specialist to see what they can do for her urinary frequency as different medicine had been attempted which R5 thought is had helped. R5 also stated the physician was going to do something else, but she didn't know when.

On 7/15/16, at 8:45 a.m. registered nurse (RN)-A stated she did not know who was responsible for following up on physician orders and did not know why anything wasn't done about R5's urology follow up.

On 7/15/16, at 10:08 a.m. the facilities clinical director consultant stated she had reviewed R5's medical record and confirmed there was no

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F 504	Continued From page 57 documentation which indicated labs, follow up, or an attempt to schedule the Botox appointment was completed as directed by R5's physician's order on 5/27/16 urology visit. On 7/15/16, at 1:19 p.m. the director of nursing (DON) verified R5's physician's orders should have been addressed and followed up on. The DON stated it was her expectation that all orders be followed. A facility policy for following/implementing physician's orders was not provided.	F 504		

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

F5323025

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	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/12/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Golden Living Center of Walker was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones. The building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system and in common areas that is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), which is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a	K 000		

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

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.

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

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K 000	Continued From page 1 census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
July 29, 2016

Ms. Tracy Hendrickx, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5323025, H5323015, H532306

Dear Ms. Hendrickx:

The above facility was surveyed on July 11, 2016 through July 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5323016 and H5323016 that were found to be unsubstantiated. 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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@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.

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

Sincerely,

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

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

Minnesota Department of Health

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GOLDEN LIVINGCENTER - WALKER	**209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484**

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

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	00995	A. BUILDING: ______ B. WING ______	07/15/2016

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 11th, 12th, 13th, 14th and 15th, 2016, 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. An investigation of complaints H5323015 and H5323016 were completed and found not to be substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 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		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		8/22/16

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2 302	Continued From page 3	2 302		
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's training for 2 of 4 nursing assistants (NA-F, NA-G) and for 1 of 1 dining service manager (DSM). This had the potential to affect all 26 residents who resided in the facility. Findings include: NA-F was hired on 1/30/15, and the employee record lacked evidence of having received the required Alzheimer's training. NA-G was hired on 3/6/15, and the employee record lacked evidence of having received the required Alzheimer's training. DSM was hired on 5/5/15, and the employee record lacked evidence of having received the required Alzheimer's training. On 7/14/16, at 8:33 a.m. administrator confirmed the facility lacked documentation that NA-F, NA-G and DSM had completed their Alzheimer's training. The administrator confirmed all three of these employees should have completed the training. On 7/15/16, at 1:32 p.m. administrator confirmed NA-F, NA-G and DSM are current employees of the facility. No policy related to Alzheimer's training was provided.		Corrected.	

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2 302	Continued From page 4 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 302		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide 1 of 2 residents (R12) with the appropriate notification of a roommate change. Findings include:	2 435	Corrected.	8/22/16

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2 435	Continued From page 5	2 435		

On 7/12/16, at 9:50 a.m. R12 stated R18 had moved into his room about a month ago (R18 moved in with R12 on 6/22/16). R12 stated he had not been notified of the roommate change prior to R18 moving in.

On 7/14/16, at 10:00 a.m. social worker (SW) confirmed when a resident moved into a room which had a resident already occupying that room, two forms were to be competed. SW confirmed one form was completed by the resident requesting or being asked to make the room change and the second form was completed and given to the resident as notification that they would be receiving a new roommate. SW stated if both residents agreed to the move, then the move could occur right away. However, if one of the residents hadn't agreed to the move, then there was a seven day adjustment period before the move occurred. SW verified R12 (resident who received a new roommate) had not been provided or signed the Notice Getting A Roommate form. SW stated she had been on vacation when R18 moved into R12's room and SW was unsure of who followed through on the notification of roommate and/or room changes in the SW's absence. SW confirmed any time there was a conversation regarding a room/roommate change that conversation should be documented in the residents' medical record. SW confirmed R12's medical record lacked documentation regarding notification of R12 getting a roommate. SW verified R12 had told her that he (R12) had not been made aware that he would be getting a roommate prior to R18 moving in. SW confirmed R18 had been given notice of the room change

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2 435	Continued From page 6 on 6/15/16. R18 had refused to sign the notice, so the seven day adjustment period was provided with R18 moving into R12's room on 6/22/16. On 7/14/16, at 10:29 a.m. the administrator confirmed prior to a resident room change and/or roommate change the appropriate notification should be provided. The administrator stated potential roommate compatibility was taken into consideration prior to a roommate change and she expected all conversations regarding room/roommate changes to be documented in the appropriate medical record. The administrator confirmed the SW was the one who made sure the appropriate notifications were given and signed and would document these conversations in the residents' medical record. R12's nursing progress notes (PN) from 6/15/16, through 7/13/16, lacked documentation of appropriate notification of a roommate change or a follow up assessment of the roommate change. Resident Room Relocation policy dated 2/26/15, indicated the social service staff would be involved with any resident room relocations. The resident's social, emotional and cognitive needs would be assessed and considered prior to relocation of the resident. The impact of room relocation on the resident's psychosocial status would be assessed by the social service staff. The social service staff would work with the interdisciplinary team to consider roommate compatibility to arrive at the most appropriate location for a resident. In addition, a plan would be developed by the social service staff to assure the needs and concerns related to the residents'	2 435		

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2 435	Continued From page 7	2 435		

ability to cope and adjust to the relocation would be addressed by:
- A verbal noticed would be provided to the resident or family that was being relocated and this would be documented in the medical record.
- Room options would be given when possible.
- Resident would be introduced to their new roommate.
- The resident and/or their family would be informed that they were receiving a new roommate.
- The identified social, emotional, and cognitive need related to the room relocation would be addressed.
- A follow up visit would made as needed by the social service staff to aid in the adjustment to the move.
- Social service staff would document the resident's response to the move in the medical record.

General Guidelines for Transfer of Resident within the Facility policy dated 5/3/16, indicated the residents or their responsible parties would be notified in advance of the transfer. All roommates affected by the transfer would be notified. A change of room or roommate notice would be provided. In addition, how well the resident tolerated the move should be documented.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the social worker/designee to update policies and procedures for when to notify the resident(s) of room/roommate changes, and then could educate staff. The DON or designee could also perform audits of resident records to determine if

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2 435	Continued From page 8 the resident(s) had been notified as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the comprehensive care plan to include interventions for pressure ulcer management for 1 of 1 resident (R19) who had acquired a pressure ulcer. Findings include: R19's quarterly Minimum Data Set (MDS) dated 6/6/16, indicated R19 was diagnosed with Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all	2 570	Completed.	8/22/16

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2 570	Continued From page 9 activities of daily living, and was at risk for pressure ulcers and had developed an unstageable pressure ulcer. R19's weekly skin review, dated 6/4/16, indicated R19 had developed and area of eschar to her left heel. R19 was seen by the physician's on 6/6/19 for left heel pressure ulcer, with referral to the wound clinic and cushion device to help relieve pressure. R19's wound clinic visit, 6/9/16, indicated orders for a Mepilex border heel dressing, staff to change dressing every other day and to wear a pressure relieving boot. R19's physician order dated, 7/6/16, indicated dressing change: Apply wet to dry dressing daily to left heel, ok to shower, wound should be washed with soap and water with each dressing change. R19's care plan, print date 7/14/16, lacked revision to include R19's pressure ulcer and interventions related to R19's unstageable left heel pressure ulcer. On 7/14/16, at 3:23 p.m. the director of nursing (DON) stated, R19's care plan should have been revised to include the needed interventions when the pressure ulcer developed. The facilities Skin Care Protocol, undated, indicated the interdisciplinary plan of care would	2 570		

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2 570	Continued From page 10 address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified. The facility procedure guide, Dressing Change, dated 2/4/16, identified care plan documentation guidelines, directing staff to identify the appropriate problem under which to list the dressing change as an approach, list measurable goals, list responsible discipline, with instruction unique to resident, monitoring and observations and preventive measures. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		8/22/16

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2 830	Continued From page 11	2 830		
	of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure physician orders were followed for 1 of 1 resident (R19) who required pressure ulcer wound care.		Corrected.	
	Findings include:			
	R19 did not receive pressure ulcer wound care as directed by the physician orders.			
	R19's quarterly Minimum Data Set (MDS) dated 6/6/16, indicated R19 was diagnosed with Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all activities of daily living (ADLs), required extensive assist with positioning, was at risk for pressure ulcers and had developed an unstageable pressure ulcer.			
	R19's physician order report print date 7/14/16, indicated: Apply wet to dry dressing daily to left heel, ok to shower, wound should be washed with soap and water with each dressing change (order date 7/6/16).			

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2 830	Continued From page 12	2 830		

On 7/14/16, at 3:06 p.m. licensed practical nurse (LPN)-C was observed during R19's left heel pressure ulcer dressing change. LPN-C gloved and removed R19's pressure relief boot and slipper sock from her left foot. A gauze 4 X 4 was removed from the wound. LPN-C measured the left heel pressure ulcer and stated the wound measured 1.5 centimeters (cm) by 1.9 cm. LPN-C removed her gloves and opened two 4 X 4 gauze dressing packages, obtained two pieces of tape, applied saline wound wash to the gauze 4 X 4 and washed the wound using a circular motion. A small amount of debris was observed to be removed from the wound. LPN-C removed her gloves and regloved. LPN-C applied saline to a gauze 4 X 4 and applied it to R19's pressure ulcer wound and applied a dry gauze 4 X 4 over the wet 4 X 4 followed by wrapping the left heel with kerlix gauze to secure the dressing. LPN-C removed her gloves and applied R19's slipper sock and pressure relief boot, LPN-C then washed her hands.

At 3:19 p.m. LPN-C reviewed R19's order for dressing change, and stated the physician order indicated to wash the wound with soap and water. LPN-C verified she did not follow the physician's order, and should have washed the wound with soap and water prior to applying the dressing.

On 7/14/16 at 3:23 p.m. the director of nursing (DON) stated, it was her expectation the nurse follows the physicians order as directed. The dressing change should have been completed as the physician ordered.

A facility policy for following/implementing

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2 830	Continued From page 13 physicians orders was not provided. R5's physician orders were not followed regarding urinary incontinence needs. R5's quarterly MDS dated 4/18/16, indicated R5 was diagnosed with Diabetes, anxiety and disorders of the bladder. The MDS also indicated R5 was cognitively intact, required extensive assist with toileting, and had frequent incontinence of bladder. R5's Urinary Incontinence Care Area Assessment (CAA) dated 7/13/16, indicated R5 had urinary urgency, required assistance in toileting, had functional incontinence and the overall objective was to minimize risks. R5's Urology visit on 3/25/16, indicated Ditropan (treats overactive bladder) was ineffective, so R5 was to try Vesicare 10 milligrams (mg) (treats overactive bladder). Could consider Botox instillation interavesical. R5's Urology visit on 5/27/16, indicated a recommended physician's order to get a UA (urine test) which would be easier done at the home facility when R5 was in bed, then fax results to physician and if the UA was positive for infection, R5 would be treated for a urinary tract infection (UTI) until clear and then arrange for Botox treatment thereafter. The report indicated R5 was comfortable with that approach would like to proceed with further management.	2 830		

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2 830	Continued From page 14	2 830		

R5's clinical record lacked indication the UA was completed and results faxed to the physician, or any further follow up related to R5's urology visit.

On 7/13/16, at 1:15 p.m. nursing assistant (NA)-A stated R5 needed to go to the bathroom a lot, sometimes 15-30 times in an 8 hour shift. NA-A stated she had assisted R5 to the commode 12 times on my shift so far.

On 7/14/16, at 8:59 a.m. R5 stated the girls came and helped her but sometimes she cannot wait until they get here and my urine just comes out. R5 stated she was going to see a specialist to see what they can do for her urinary frequency as different medicine had been attempted which R5 thought is had helped. R5 also stated the physician was going to do something else, but she didn't know when.

On 7/15/16, at 8:45 a.m. registered nurse (RN)-A stated she did not know who was responsible for following up on physician orders and did not know why anything wasn't done about R5's urology follow up.

On 7/15/16, at 10:08 a.m. the facilities clinical director consultant stated she had reviewed R5's medical record and confirmed there was no documentation which indicated labs, follow up, or an attempt to schedule the Botox appointment was completed as directed by R5's physician's order on 5/27/16 urology visit.

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2 830	Continued From page 15 On 7/15/16, at 1:19 p.m. the director of nursing (DON) verified R5's physician's orders should have been addressed and followed up on. The DON stated it was her expectation that all orders be followed. A facility policy for following/implementing physician's orders was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to following physician orders and follow up services as written. The DON or designee, could provide training for all nursing staff on implementation of physician orders. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required.	21290		8/22/16

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21290	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R18) who was reviewed for timely physician visits had received a physician visit every 30 days for the first three months. Findings include: R18's admission Minimum Data Set (MDS) dated 5/12/16, indicated R18 had been admitted to the facility on 5/12/16, with diagnoses which included anemia, coronary artery disease, heart failure, hypertension, gastroesophageal reflux, end stage renal disease, diabetes, and depression. R18's clinical record indicated R18 had been evaluated by a physician's assistant (PA)-A on 5/18/16, went to a follow up appointment with a surgeon on 6/28/16, and was evaluated by R18's primary medical doctor (MD)-A on 7/14/16. Physician Visit Control Log for 2016, indicated R18 was scheduled to be seen by MD-A on 5/17/16, 6/16/16, and 7/14/16. R18's progress note dated 6/30/16, indicated MD-A did not see R18 when MD-A rounded at the facility. On 7/15/16, at 10:21 a.m. licensed practical nurse	21290	Corrected.	

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21290	Continued From page 17 (LPN)-A stated she was unsure why MD-A missed evaluating R18 in June. LPN-A confirmed she had contacted R18's primary clinic and the clinic verified R18 had not been seen by MD-A, on 6/16/16, as scheduled. On 7/15/16, at 2:05 p.m. director of nursing (DON) and assistant director of nursing (ADON) confirmed R18 should have been seen by a physician once a month for the first three months following admission to the facility. After the 30, 60, and 90 day evaluations by a physician, then a physician could evaluate R18 every other month. The DON and ADON confirmed R18's 60 day visit should have occurred by 6/21/16. A facility policy on physician visit schedules was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to frequency of physician visits. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21290		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing	21325		8/22/16

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21325	Continued From page 18 home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dental services for 1 of 3 residents (R14) reviewed for dental services. Findings include: R14's undated Face Sheet indicated R14 was diagnosed with multiple sclerosis (MS), major depression and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated 5/16/16, indicated R14 had not issues with oral/dental status and R14 required extensive assistance for oral cares and was non-ambulatory. R14's Activities of Daily Living Care Area Assessment dated 12/8/15, indicated R14 required extensive assist with dressing secondary to limited range of motion, poor balance, and generalized weakness as related to MS and a poor memory. R14's care plan dated 5/13/16, directed staff to assist with oral care two times a day and refer to dental services as needed.	21325	Corrected.	

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On 7/12/16, at 9:15 a.m. R14 was observed to have multiple missing, broken, and loose teeth. R14 stated she was losing her teeth. R14 stated the staff would not help her with dental visits because she had MS, was on UCARE insurance, and added "I am not on welfare."

R14's faxed order sheet dated 2/17/16, indicated R14 had been complaining of pain and a dental appointment had been made for 2/23/16. In addition, the faxed order sheet queried the doctor and asked if R14 required antibiotics, R14 was on Tylenol and Tramadol PRN (as needed) for pain, and R14's family was wondering about an antibiotic for oral pain, until R14's appointment on 2/23/16. The physician response dated 2/18/16, directed staff to "hold off on antibiotic for now, call if worse." No other information on R14's dental issue was noted in the medical record regarding dental appointments or recommendations.

The 2/19/2016, Quarterly Interdisciplinary Resident Review form, indicated R14 had no "broken, loose, or carious teeth."

R14's nurse progress note dated 6/8/16, indicated R14 had a broken tooth on the upper right side of her mouth. further documentation read:

"Background: R14 had some dental caries, states that she has tried to obtain dental care in the past and has been rejected by clinics due to type of insurance she has."
Assessment: Upper right pre-molar appeared to have splintered. R14 denied any pain or hot/cold sensitivities at that time. No swelling, bleeding, or exposed root visible.
Response: Recommend attempt to find dental

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21325	Continued From page 20 care for resident. No additional information on R14's dental issue was noted in the medical record. On 7/13/16, at 12:45 p.m. licensed practical nurse (LPN)-B stated R14 was seen by a dentist 2/23/16, and was referred to Northern Dental in Bemidji who could not pull the teeth. At that time, Northern Dental referred R14 to an oral surgeon in Fargo. LPN-B stated that facility wanted $1000.00 in which R14's daughter was notified. At the time of the appointment, R14 utilized UCARE insurance. However, R14's medical record lacked documentation regarding the 2/23/16, Northern Dental visit, the recommendation for follow up care with an oral surgeon in Fargo or that R14's daughter had been informed of R14's dental service needs/cost of service. On 7/14/16, at 10:50 a.m. during a telephone interview, R14's daughters confirmed an appointment had been made for R14 to go to Fargo and stated she had advised the facility that her mother could not make the trip due to R14's current physical/medical status because it was too far for her mother to travel. R14 also stated she was told by the facility that there was no local place that would accept R14's insurance unless R14 went to Fargo. R14's daughter stated this was in Feb or March, and nothing had happened with her mother's teeth since then. R14's daughter stated her mother had an infection in her mouth because of the needed teeth extractions and it was absolutely uncalled for that nobody would take care of her mother's teeth. On 7/14/16, at 2:45 p.m. R14 stated she had pain in her mouth all the time and especially had	21325		

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discomfort when she chewed her food. R14 stated she had one tooth in her mouth that she had to periodically push down so it stayed in her mouth. R14 stated again that she was under UCARE insurance which was not welfare, and felt someone should be able to take care of her dental needs.

On 7/15/16, at 8:35 a.m. the director of nursing (DON) and assistant director of nursing (ADON) were interviewed regarding R14's dental needs. Review of the medical record with the DON, indicated on 2/18/16, R14 was given Tramadol 50 milligrams (mg) for oral pain which was effective. The DON verified the doctor was contacted regarding starting on an antibiotic on 2/18/16, due to R14's complaints of oral pain. The DON and ADON verified staff had not documented in the medical record regarding R14's dental appointments. The DON verified R14's dental needs were not met and the facility would be working on getting her an appropriate appointment to see the dentist for her teeth issues. The DON also stated the staff would be trained on documenting dental appointments in each residents' medical record.

A policy on Dental Services was requested, however no policy was received.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies/procedures and provide staff training related to assessment and care for residents regarding dental services. The quality assessment and assurance committee could perform random audits to ensure

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21325	Continued From page 22 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		8/22/16

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21390	Continued From page 23	21390		
	Based on observation, interview and document review, the facility failed to ensure proper hand hygiene was implemented for 1 of 1 resident (R19) observed for wound care. In addition, the facility failed to ensure wheelchair cushions were properly covered for 2 of 2 residents (R2, R28) to ensure cleanable and sanitary surfaces were provided.		Corrected.	
	Findings Include:			
	R19's wound care was observed and the facility failed to implement proper hand hygiene during the provision of the wound care.			
	R19's quarterly Minimum Data Set (MDS) dated 6/6/16, indicated R19 was diagnosed with Alzheimer's disease, had severely impaired cognition, was totally dependent on staff for all activities of daily living (ADLs), required extensive assist with positioning, was at risk for pressure ulcers and had developed an unstageable pressure ulcer.			
	R19's physician order report print date 7/14/16, indicated: Apply wet to dry dressing daily to left heel, ok to shower, wound should be washed with soap and water with each dressing change (order date 7/6/16).			
	On 7/14/16, at 3:06 p.m. licensed practical nurse (LPN)-C was observed performing R19's left heel pressure ulcer dressing change. LPN-C gloved and removed R19's pressure relief boot and slipper sock from her left foot. A gauze 4 X 4 was			

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removed from the wound. LPN-C measured the left heel pressure ulcer and stated the wound measured 1.5 centimeters (cm) by 1.9 cm. LPN-C removed her gloves and opened two 4 X 4 gauze dressing packages, obtained two pieces of tape, applied saline wound wash to the gauze 4 X 4 and washed the wound using a circular motion. A small amount of debris was observed to be removed from the wound. LPN-C removed her gloves and regloved. LPN-C applied saline to a gauze 4 X 4 and applied it to R19's pressure ulcer wound and applied a dry gauze 4 X 4 over the wet 4 X 4 followed by wrapping the left heel with kerlix gauze to secure the dressing. LPN-C removed her gloves and applied R19's slipper sock and pressure relief boot, LPN-C then washed her hands.

-At 3:19 p.m. LPN-C verified she did not wash her hands after removing her gloves throughout the provision of wound dressing change treatment and should have. LPN-S verified she had training on gloving and the dressing change process.

On 7/14/16 at 3:23 p.m. the director of nursing (DON) stated, it was her expectation for the nurse to wash her hands after removing gloves and prior to donning clean gloves during a dressing change. The DON stated the facility would make sure training was provided to all staff who perform dressing changes to make sure the procedure and policy was followed.

The facility policy, Handwashing/Hand Hygiene, dated 2/4/16, indicated the facility considered hand hygiene the primary means to prevent the spread of infections and all personnel shall follow the handwashing/hand hygiene procedures to

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help prevent the spread of infections.

R2 and R19's wheelchair positioning cushions lacked cushion covers to ensure sanitary and cleanable surfaces.

R2's diagnosis list dated 7/15/16, identified diagnosis of edema, muscle weakness dermatitis, overactive bladder and epilepsy.

R2's quarterly minimum data set (MDS) dated 6/2/16, indicated R2 was totally dependent on staff for transfers to wheelchair, was at risk for pressure ulcers, was frequently incontinent of bowel and bladder and utilized a pressure reducing device for bed and chairs.

On 7/13/16, at 12:30 p.m. and during intermittent observations throughout the survey from approximately 8:00 a.m. to 4:30 p.m. on 7/14/16, and 7/15/16, R2's was observed seated in a wheelchair with an uncovered, yellow, foam pummel shaped seat cushion. The foam was uncleanable.

R28's quarterly MDS dated 4/27/16, identified diagnosis of indicated R28 required extensive assist with transferring and position between surfaces- bed-wheelchair. The MDS further indicated, R28 was at risk for pressure ulcers and utilized a pressure reducing device on his bed and chair.

R28's progress note dated 7/9/16, indicated R28 utilized a wheelchair for mobility which was

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21390	Continued From page 26 propelled by staff. On 7/12/16, at 1:21 p.m. R28 was observed seated in the wheelchair in own room. The wheelchair cushion was an uncovered, gray foam On 7/13/16, at 12:31 p.m. R28 was observed in the dining room, seated in the wheelchair on top of a gray, uncovered, foam cushion. On 7/14/16, at 11:00 a.m. R28 was observed in the hallway, seated in the wheelchair on top of a gray, uncovered foam cushion. On 7/15/16, at 9:44 a.m. R28 was observed in own room seated in the wheelchair on top of a gray, uncovered foam cushion. During a tour on 7/15/16, at 9:59 a.m. the maintenance director (MD) observed R2's cushion which a white bath towel was placed on top of the yellow foam cushion. The MD verified the cushion should have a non-permeable cushion cover on it. The MD also observed R28's wheelchair cushion and verified the grey foam cushion should also be covered. The MD stated housekeeping cleaned the wheelchairs and if the cushions became dirty, they were removed to be cleaned. The MD stated the covers should have been replaced right away prior to use. The MD verified the lack of cushion covers was an infection control concern as the foam cushions were not cleanable surfaces. The MD stated he did not believe the facility had a policy regarding cleaning cushion covers. On 7/15/16, at 1:15 p.m. the DON verified the wheelchair pressure relieving cushions should	21390		

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21390	Continued From page 27 have covers on them at all times. The DON also confirmed with the lack of cleanability, the uncovered cushions would be an infection control issue. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or their designee, could develop and implement policies/procedures and staff training related to infection control practices. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21390		
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. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		8/22/16

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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) COMPLETE DATE
21426	Continued From page 28	21426		
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees nursing assistant (NA)-G, received a tuberculosis symptom screening prior to having direct contact with residents, as required. In addition, the facility failed to ensure 4 of 5 residents (R35, R38, R44, R22) had a tuberculosis screen completed and a timely two-step tuberculin test. Findings include: The facility's Tuberculosis Exposure Control Plan policy and procedure reviewed 12/21/15, directed the staff to ensure all new admissions, new associates, and volunteers received a two-step tuberculin skin test (TST)/or chest x-ray and a TB symptom screen upon admission or upon hire with the second step TST adminsitered 7-10 after the first step TST. Employee: Nursing assistant (NA)-G was hired on 3/6/15. NA-G's personnel record lacked a tuberculosis (TB) symptom screen. Resident: R35's medical record indicated R5 was admitted to the facility on 12/30/15. R35's medical record lacked the 2nd step TB administration and a baseline TB symptomology screening. R38's medical record indicated R38 was admitted		Corrected.	

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21426	Continued From page 29 to the facility on 3/21/16. R38's medical record lacked the 2nd step TB administration and a baseline TB symptomology screening. R44's medical record indicated R44 was admitted to the facility on 5/20/16. R44's medical record lacked the 2nd step TB administration and a baseline TB symptomology screening. R22's medical record indicated R22 was admitted to the facility on 4/11/16. R22's medical record lacked the 2nd step TB administration and a baseline TB symptomology screening. On 7/15/16, at 10:15 a.m. the director of nursing (DON) verified the above findings and stated education would be completed with the licensed staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise the TB policy and develop an auditing system to ensure all residents and employees received their TB symptom screening and tuberculin skin testing. The quality assurance and assessment committee cold establish a system to audit tuberculosis testing to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21495	Continued From page 30	21495		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services to promote the psychosocial well-being for 2 of 2 residents (R12, R18) who had unresolved roommate conflicts. R12 experienced psychosocial harm due to persistent sleep disturbance and decline in mood. Findings include: R12's physician progress note dated 6/14/16, identified R12's diagnoses as history of a heart attack, heart failure, hypertension, obstructive sleep apnea (a disorder where breathing repeatedly stops and starts which occurs when the throat muscles relax), cerebral vascular accident (stroke) with left-sided weakness. R12's quarterly Minimum Data Set (MDS) dated 5/17/16, indicated R12's cognition was intact, had no signs and symptoms of a mood disorder, no behavior exhibited towards self or others during the assessment period. R12 required extensive assist with bed mobility, transferring, toileting and	21495	Corrected.	8/22/16

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personal hygiene. R12 was independent with locomotion off the unit. R12 was always continent of bladder.

R12's care plan dated 9/14/16, identified an area of focus regarding R12's safety and potential for abuse due to R12's decreased physical mobility. Interventions included not having R12 near others who disturbed him and that R12 should be removed from any potentially dangerous situations. In addition, R12's care plan indicated R12 was at risk for sleep pattern disturbances and directed staff to maintain an environment conducive to sleep (quiet, comfortable temperature, dimmed lights).

R12's Medication Administration Record (MAR) indicated R12 received Lasix (a diuretic) 20 milligrams (mg) daily. In addition, melatonin 10 mg daily for insomnia.

R18's Diagnosis Report dated 7/14/16, identified R18's diagnoses as obstructive sleep apnea, end stage renal disease, dependent on renal dialysis, and major depression.

R18's admission MDS dated 5/12/16, indicated R18 had intact cognition, was on dialysis, received a daily antidepressant, had no signs and symptoms of a mood disorder, and no behavior exhibited towards self or others during the initial assessment period.

On 7/12/16, at 9:15 a.m. during the initial resident interview with R18, R12 (R18's roommate),

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knocked on the resident's room door. R12 asked if he could come in as he (R12) had to go to the bathroom. R18 loudly responded, with R12 seated in his motorized wheelchair right outside the open door, "tell him to stay out he [R12] always has to use the bathroom." R12's request was granted and R12 entered the room, made his way to his side of the room, used the urinal and exited the room. On R12's way out, the surveyor asked if she could talk to him later. R12 stated that would be okay and that he (R12) would be in the family room.

On 7/12/16, at 9:29 a.m. the interview with R18 resumed. R18 stated R12 went to bed at 7:30 p.m. and wanted to get up at 5:00 a.m. R18 stated he [R18] normally went to bed around 10:00 p.m. and didn't get up until right before breakfast at 8:00 a.m. R18 stated R12 didn't want R18 to watch the television but "he [R18] watches it anyway." R18 stated his roommate was an "ass." R18 stated R12 spent most of his time out of the room and down by the desk. R18 stated, "It has been this way since he [R18] had moved in." R18 stated the staff were aware of the roommate situation, but the facility hadn't offered a room change. R18 confirmed that words had been exchanged between himself and R12. R18 stated he did not feel threatened by R12 and stated he "would beat the hell out of him if he [R12] tried to threaten me."

On 7/12/16, at 9:50 a.m. R12 stated R18 moved into his [R12] room about a month ago. R12 stated R18 always wanted to dominate him. R12 stated R18 "tells me what to do all the time." R12 stated R18 was not happy with him [R12] at all. R12 stated R18 liked to sit up with the television

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21495	Continued From page 33 on all night long and that R18 didn't understand that he [R12] couldn't sleep with the television on all night. R12 stated he had told R18 a couple of times to "get off my back." R12 stated R18 didn't like it because he [R12] had to go to the bathroom frequently. R12 stated R18 dominated the television, so R12 stated he spent most of his time out of the room and watched television down in the facility family room. R12 stated he hadn't said anything to anyone, however, the nursing assistants were aware of his roommate situation. R12 stated when R18 went to dialysis, he [R12] "sneaks back in the room as much as I can." R12 stated he was not afraid of R18. R12 stated he had not been notified of the roommate change prior to R18 moving into the room. -On 7/12/16, at 1:14 p.m. R12 was seated in his motorized wheelchair in the family room. -On 7/13/16, at 7:00 a.m. R12 was observed seated in his motorized wheelchair in the family room. R18 was laying in his bed in their room sleeping with the television off. -At 7:50 a.m. R12 entered their (R12 and R18's) room and used the urinal. R12 immediately exited their room after using the urinal, leaving the urinal on R12's bed side table. R12 proceeded to go back into the family room. -At 7:56 a.m. R12 was seated in his motorized wheelchair in the family room. R12's left arm dangled down onto R12's lap and both feet positioned on the foot rest with R12's heels together and legs bowed outward. R18 remained in bed sleeping in their room. -At 8:08 a.m. R12 remained seated in his motorized wheelchair in the family room. R12 had positioned a U-shaped neck pillow around	21495		

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the nape of R12's neck. R12's eyes were closed and his chin was down towards his chest.
-At 8:19 a.m. R12 remained sleeping while seated in his motorized wheelchair in the family room, while R18 had woken up and had been served breakfast in their room.
-At 8:27 a.m. R12 remained seated in his motorized wheelchair in the family room. R12 stated he would rather spend time in his room than in the family room, so he could lay down and take a nap. R12 stated R18 went to dialysis three times a week, but he [R12] wasn't aware of R18's dialysis schedule. R12 stated when he knew R18 was gone to dialysis, he spent more time in their room. R12 stated his motorized wheelchair was not comfortable to sleep in as the wheelchair was too small for him (R12 had been measured for a new wheelchair and a new motorized wheelchair was on order).
-At 9:05 a.m. R12 was sleeping while seated in his motorized wheelchair. R12's neck pillow had slightly moved off to one side.
-At 9:21 a.m. R12 was more slumped over while seated in his motorized wheelchair, sleeping.

On 7/13/16, at 11:52 a.m. licensed practical nurse (LPN)-B confirmed R12 and R18 did not get along. LPN-B stated she had heard that R18 had made the statement that he was going to continue to be mean to R12 until he [R18] got his way. LPN-B confirmed R12 spent a lot of time out of his room now. LPN-B stated she had not observed R18 being mean to R12, however, she had heard from other staff that R18 was mean to R12.

On 7/13/16, at 12:56 p.m. nursing assistant (NA)-E stated R12 and R18 got along like "oil and

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21495	Continued From page 35 water" and were "polar opposites." NA-E stated R12 was in the room first and about a month ago R18 had moved in. NA-E stated R12 liked to sleep at night and R18 was more of a night owl. NA-E stated R12's and R18's sleep hours did not match up. NA-E stated R12 spent more time in the family room since R18 moved in because R12 didn't want to be around R18. NA-E stated she was aware of times when R18 told R12 to "F-off" and R12 had told R18 to mind his own business. NA-E confirmed verbal exchanges had occurred between R12 and R18, but nothing physical. NA-E stated R12's mood and demeanor had changed since R18 had become R12's roommate. NA-E stated R12's mood had become more hostile towards the staff. NA-E stated she had informed the administrator a couple of weeks ago about how R18 had been treating R12 and that putting them together had been the worst decision. NA-E stated nothing had changed though since she had brought it to the administrator's attention. NA-E stated the nursing assistants were not asked to provide input with potential room or roommate changes. NA-E state it was hard to see someone (R12) who had been so happy to now go to being a total grump all the time. On 7/13/16, at 1:08 p.m. NA-A confirmed R12 and R18 did not get along as roommates. NA-A stated R18 liked to be up at night and R12 liked to go to bed earlier. NA-A stated R18 had sworn at R12 when R12 had to use the urinal so much. NA-A stated she had noticed a difference with R12 since R12 and R18 had become roommates. NA-A stated R12 was shorter with staff now and he (R12) used to be happier. NA-A stated R12 used to get up in the morning around 5:00 a.m. - 5:30 a.m. and now R12 doesn't get up until	21495		

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around 6:30 a.m. - 7:00 a.m. NA-A stated she thought R12 still woke up around 5:00 a.m., but now just lied awake until 6:30 - 7:00 a.m. when he (R12) felt it was okay to get up and not disturb his roommate (R18). NA-A stated before R12 and R18 became roommates, R12 would lay down a lot more and usually took a nap in his room or would just kick back in his wheelchair and watch television in his room. NA-A stated now R12 spent most of his time out of his room and in the family room. NA-A stated sometimes when R18 was at dialysis, R12 would go into his room and laid down. NA-A stated when R18 hollered at R12, R12 just put his head down and doesn't respond to R18, it's like he [R12] was just trying to ignore R18. NA-A stated the NAs used to provide input regarding potential room or roommate changes, however, the NAs hadn't been asked in a long time to provide input. NA-A stated it wasn't a good idea to put R12 and R18 together. NA-A stated she thought this move had definitely impacted R12 more than R18, and in a negative way.

On 7/13/16, at 2:07 p.m. NA-F stated R12 and R18 argued about the television a lot. NA-F stated R12 used to go to bed right after dinner and now R12 doesn't go to bed until about 8:00 p.m. (staying up about two hours later than R12's past preference/routine). NA-F stated R12 used to go into his room around 3:00 p.m. and took a nap, but now R12 only went into his room to nap if R12 noticed that R18 was at dialysis. NA-F stated she thought R12 now napped in his wheelchair in the family room a lot during the daytime. NA-F stated R18 stayed up late and watched television and that R18 liked to sleep with the television on. NA-F stated she thought most evenings the television was left on during

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21495	Continued From page 37 the night because that was how R18 liked it. NA-F stated R12 appeared more moody since R18 had become R12's roommate. On 7/14/16, at 8:37 a.m. R12 was observed seated in his motorized wheelchair in the activity room watching television. On 7/14/16, at 8:53 a.m. NA-C stated R12 and R18 should never have become roommates. NA-C stated R18 had told R12 that he [R12] did not need to get up at 5:00 a.m. When R18 told R12 this, NA-C stated she had written on a piece of paper that R12 could get up whenever he (R12) wanted to and showed the note to R12. NA-C stated R12 "shook his head yes." However, NA-C stated now R12 stayed in bed until around 7:00 a.m. (two hours later than R12's past preference/routine). NA-C stated R18 had told R12 "if you didn't have to drink so much you wouldn't have to use that urinal so much." NA-C stated R12 had told her that he was ready to pop R18 one. NA-C stated R18 liked to have the television on all the time and NA-C had thought the facility was going to get another television in the room. However, NA-C stated she didn't think that would resolve the roommate problem. NA-C confirmed R12 spent more time out his room since R18 became R12's roommate. NA-C stated R12 used to take a nap in R12's room, but now R12 spent the majority of the time in the family room. NA-C stated she had expressed on two different occasions to the nurse in charge regarding R12 and R18's roommate situation. NA-C stated the first time she brought it up was around 6/23/16. NA-C stated she had seen a change in R12 since R18 became R12's roommate. R12 used to get up and be bubbly	21495		

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and smile and now R12 was more withdrawn and doesn't talk much. NA-C confirmed it was a daily occurrence on how R18 treated R12.

On 7/14/16, at 9:35 a.m. NA-E confirmed the verbal interactions from R18 to R12 happened pretty much daily - if it didn't happen then that would be a "good day".

On 7/14/16, at 9:24 a.m. NA-A confirmed the verbal interactions from R18 to R12 happened daily. NA-A stated for example this morning R12 was in the bathroom being assisted with cares by NA-A, and R12 told NA-A that he [R12] was just being smart. NA-A stated R18 hollered "you are always a smart ass." NA-A stated it was stuff like this that happened daily.

On 7/14/16, at 9:53 a.m. R12 was observed seated in his wheelchair on the patio. R12 stated he didn't sleep as well as he used to since R18 became his roommate and he was always tired now. R12 stated he didn't want to talk about R18 anymore.

On 7/14/16, at 10:00 a.m. R12 was interviewed by another surveyor as R12 was an active member of the resident council. R12 confided to this surveyor that the facility was currently working on getting R18 away from R12. R12 stated R18 always yelled at him. R12 stated R18 had the television remote, so when R18 had the television on, R12 just rolled over. R12 stated R18 kept the television on and R12 felt the television caused flashes of light which kept him awake. R12 stated he was just going to keep his

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mouth shut until he [R12] could be moved.

R12's Care Conference Summary note dated 7/12/16, indicated under the family/resident comment section that R12 had expressed the following:
- having R18 in R12's room was disturbing
- R18 thought he was the boss
- R18 had the television on at night and R18 complained continuously about R12 making noise in the room and having to use the urinal.

R18's nursing progress note (PN) from 6/15/16, through 7/13/16, lacked documentation regarding R18's unresolved roommate conflict with R12.

R12's PN from 6/15/16, through 7/13/16, lacked documentation regarding R12's unresolved conflict with R18. In addition, R12's medical record lacked documentation of appropriate notification of a roommate change or a follow up assessment of the roommate change.

On 7/14/16, at 10:00 a.m. social worker (SW) confirmed the facility was not at full capacity which was 40 and the current census was 26 residents. SW stated when a resident requested a room change a form was completed and when a resident moved into a room which had a resident already occupying that room, then two forms were to be competed. SW stated one form was completed by the resident requesting or being asked to make the room change and the second form was completed and given to the resident as notification that they would be receiving a new roommate. SW stated if both

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21495	Continued From page 40 residents agreed to the move, then the move could occur right away. However, if one of the residents hadn't agreed to the move, then there was a seven day adjustment period before the move occurred. SW verified R12 (resident who received a new roommate) had not been provided or signed the Notice Getting A Roommate form, as required. SW stated she had been on vacation when R18 moved and SW was unsure of who followed through on the notification of roommate and/or room changes in the SW's absence. SW confirmed any time there was a conversation regarding a room/roommate change that conversation should be documented in the residents' medical record. SW confirmed R12's medical record lacked documentation regarding notification of R12 getting a roommate. SW verified R12 had told her that he had not been made aware that he would be getting a roommate prior to R18 moving in. SW confirmed R18 had been given notice of the room change on 6/15/16. R18 had refused to sign the notice, so the seven day adjustment period was provided with R18 moving into R12's room on 6/22/16. SW confirmed R12 and R18 did not get along well as roommates. SW stated on 7/12/16, R12 held a care conference which R12's son also attended along with R12. SW stated at the care conference, R12 expressed his displeasure of being roommates with R18. SW stated R12's main concern focused on the television and how R18 liked to have the television on all night long and because the television was positioned directly at the foot of R12's bed the flickering bright lights from the television kept R12 awake at night. In addition, R12 voiced concerns that R18 always wanted to be the boss and that R18 always complained of the noise that R12 made. R12's son also expressed at the care conference that he was worried about R12 getting enough	21495		

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21495	Continued From page 41 sleep and felt since R18 had moved in, R12 had not slept as well. SW stated "most definitely" she felt the roommate situation between R12 and R18 had negatively impacted R12's psychosocial well-being, especially after what had been brought up at the care conference. SW stated she expressed to the leadership team at their stand up meetings these last couple of days, her concerns regarding R12 and R18's roommate situation. SW stated she thought they should move R18, however, the leadership team thought R12 should be the one that moved because R12 had requested to move. SW confirmed R12's most recent mood and behavior assessment conducted 5/17/16, identified no mood or behavioral concerns. SW stated she would expect if R12's mood evaluation was completed now, it would be different and show a decline in R12's mood. SW stated overall she felt R12 was less satisfied with R12's current situation. On 7/14/16, at 10:29 a.m. the director of nursing (DON) and administrator confirmed the facility had open resident rooms. The administrator confirmed prior to a resident room change and/or roommate change the appropriate notification was to be provided. The administrator stated she had spoken to both R12 and R18 yesterday (7/13/16) and had offered to move R12 to a temporary room. Then when R12's potential new roommate had been provided proper notice, the facility would again move R12 into that room with the new roommate. The administrator stated R12 declined the temporary move as he didn't want to move twice. R12 opted to wait until proper notice was provided to his potential new roommate and then be relocated. The administrator stated R12 was being moved because R12 had made the request to be moved. The administrator stated	21495		

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21495	Continued From page 42 potential roommate compatibility was taken into consideration prior to a roommate change and the nurse managers also gathered input from the other staff which included the NAs and the resident and family. Other things considered were the safety with the equipment in the room, if the residents liked the television on, and most definitely sleep routines. The administrator stated the NAs had made her aware today (7/14/16) that R12 and R18 had argued last evening, and last Friday (7/8/16). The administrator stated the NAs had made her aware of the conflicts with the television and that R18 liked to have the television on all the time. The administrator confirmed some tension existed between R12 and R18. The administrator verfied R12's psychosocial well-being had been affected in a negative manner since R18 and R12 became roommates. In addition, the administrator stated she was aware R12 was not comfortable with the current roommate arrangement and was aware that R12 was frustrated. R18's medical record indicated on 7/14/16, at 2:32 p.m. R18 had been moved to another room. On 7/15/16, at 8:53 a.m. R12 stated it had been so nice and quiet in his room last night and it was so nice to be able to get up in the morning when he wanted. Resident Room Relocation policy dated 2/26/15, indicated the social service staff would be involved with any resident room relocations. The resident's social, emotional and cognitive needs would be assessed and considered prior to relocation of the resident. The impact of room relocation on the resident's psychosocial status would be assessed by the social service staff.	21495		

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The social service staff would work with the interdisciplinary team to consider roommate compatibility to arrive at the most appropriate location for a resident. In addition, a plan would be developed by the social service staff to assure the needs and concerns related to the residents' ability to cope and adjust to the relocation would be addressed by:
- A verbal noticed would be provided to the resident or family that was being relocated and this would be documented in the medical record.
- Room options would be given when possible.
- Resident would be introduced to their new roommate.
- The resident and/or their family would be informed that they were receiving a new roommate.
- The identified social, emotional, and cognitive need related to the room relocation would be addressed.
- A follow up visit would made as needed by the social service staff to aid in the adjustment to the move.
- Social service staff would document the resident's response to the move in the medical record.

General Guidelines for Transfer of Resident within the Facility policy dated 5/3/16, indicated the residents or their responsible parties would be notified in advance of the transfer. All roommates affected by the transfer would be notified. In addition, how well the resident tolerated the move should be documented.

SUGGESTED METHOD OF CORRECTION:

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21495	Continued From page 44 The director of nursing (DON) and/or designee could review or revise policies, and provide education for staff regarding assessment and follow through on identified resident psychosocial needs. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is	21530		8/22/16

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21530	Continued From page 45 being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facilty failed to act upon the consulting pharmacist's recommendations for 1 of 5 residents (R18) who had ongoing consulting pharmacist recommendations which were not acted upon, as required. Finding include: R18's Diagnosis Report dated 7/14/16, identified R18's diagnoses as gastro-esophageal reflux disease (GERD-heart burn), obstructive sleep apnea (a sleep disorder when breathing repeatedly stops and starts which occurs when the throat muscles relaxes), end stage renal disease, dependent on renal dialysis, diabetes, heart failure, hypertension and major depression. R18's admission Minimum Data Set (MDS) dated 5/12/16, indicated R18 was on dialysis and	21530	Corrected.	

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21530	Continued From page 46 received a daily dose of insulin and an antidepressant. R18's Psychotropic Drug Use Care Area Assessment (CAA) dated 5/20/16, indicated R18 had not been taking a sedative/hypnotic. R18's Order Summary Report dated 7/14/16, directed staff to administer: - Pantoprazole Sodium delayed release 40 milligrams (mg) twice a day (medication usually used short term to treat GERD and excessive acid production) - temazepam 15 mg every evening as needed (medication used to treat insomnia) R18's Pharmacy Review notes dated 5/16/16, 6/13/16, and 7/11/16, repeatedly indicated that the consulting pharmacist (CP) had recommended a gradual dose reduction (GDR) be considered for pantoprazole. In addition, consideration be taken for a GDR for temazepam if not being used. R18's medication administration records (MAR) for May, June and July 2016, indicated R18 had not taken the temazepam at all and had on occasion refused a dose of R18's scheduled pantoprazole. R18's provider progress note dated 7/14/16, lacked acknowledgement of the CP's above noted recommendations.	21530		

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On 7/15/16, at 8:37 a.m. licensed practical nurse (LPN)-B confirmed R18 had temazepam ordered when needed at bedtime for sleep, however, R18 had not been administered the temazepam for the month of July.

On 7/15/16, at 1:42 p.m. director of nursing (DON) confirmed R18 had current orders for and had received pantoprazole delayed release (DR) 40 mg twice a day. In addition, the DON confirmed R18 had temazepam 15 mg ordered as needed at night and had not taken the temazepam since the medication had been ordered (5/12/16). The DON also confirmed the above noted CP recommendations dated 5/16/16, 6/13/16, and 7/11/16, regarding the considerations for GDR's for both R18's temazepam and pantoprazole and stated it was her expectation that these recommendations be followed up upon in a timely manner. The assistant director of nursing (ADON) stated an e-mail was sent each month by the CP which included the CP's recommendations for each resident in which she placed a copy of these e-mails into the physician's mailbox for the physician's review when the physician came for rounds the next time. The ADON confirmed she never reviewed the CP's monthly pharmacy review note in the computer which included the CP's monthly recommendations. The ADON confirmed she had rounded with the physician the day prior (7/14/16), however, was unsure if the physician had received R18's recommendations from the pharmacists monthly drug regime review for May, June or July 2016.

On 7/15/16, at 2:56 p.m. the CP confirmed he documented each month in the medical record

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his recommendations for each resident based on the CP's monthly resident medication regime review. In addition, the CP stated he sent an e-mail each month to the ADON with the same recommendations he had articulated in the pharmacy review note which was already available in the resident's medical record. The CP verified he had made recommendations for GDR's for R18's temazepam and pantoprazole for the last three months and stated it would be his expectation that these recommendations be brought to the physician's attention and acted upon.

Consultant Pharmacist Services Provider Requirements policy dated 5/12, indicated the CP would review the medication regimen of each resident at least monthly and this review would be documented in the resident's medical record or a readily retrievable format. The CP would communicate monthly to the responsible prescriber and the facility leadership recommendations for changes in medication therapy.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to assurance that consulting pharmacist recommendations are followed up upon. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21530	Continued From page 49 (21) days	21530		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a hypnotic medication was available as prescribed for 1 of 1 resident (R18) who had an as needed (PRN) hypnotic prescribed. Findings include: R18's Diagnosis Report dated 7/14/16, identified R18's diagnoses as gastro-esophageal reflux disease (GERD-heart burn), obstructive sleep apnea (a sleep disorder when breathing repeatedly stops and starts), end stage renal disease, dependent on renal dialysis, diabetes, heart failure, and major depression. R18's admission Minimum Data Set (MDS) dated 5/12/16, indicated R18 was on dialysis and received a daily dose of insulin and an antidepressant. R18's Psychotropic Drug Use Care Area	21550	Corrected.	8/22/16

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Assessment (CAA) dated 5/20/16, indicated R18 had not been taking a sedative/hypnotic.

R18's Order Summary Report dated 7/14/16, directed staff to administer temazepam 15 milligrams (mg) every evening as needed (medication used to treat insomnia). R18's temazepam had initially been ordered on 5/12/16.

R18's Pharmacy Review notes dated 5/16/16, 6/13/16, and 7/11/16, repeatedly indicated the consulting pharmacist (CP) had recommended a gradual dose reduction (GDR) be considered for temazepam as R18 had not been using the medication.

R18's medication administration records (MAR) for May, June and July 2016, indicated R18 had not been administered the temazepam 15 mg at bedtime as ordered.

On 7/15/16, at 8:37 a.m. licensed practical nurse (LPN)-B confirmed R18 had temazepam ordered when needed at bedtime for sleep, however, R18 had not been administered the temazepam for the month of July. LPN-B commented that she didn't know if the facility even had the medication in the medication cart to give R18, if he had requested. LPN-B thought there may have been some evenings where R18 would have used the medication.

On 7/15/16, at 2:06 p.m. assistant director of nursing (ADON) verified the facility did not have temazepam available for R18. Both the director

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of nursing (DON) and ADON confirmed it was the expectation that the facility have all of R18's ordered medications available for R18. The DON confirmed the pharmacy in town filled the residents' medications. The ADON was unable to articulate a reason why R18's temazepam which had been ordered on 5/12/16, was still unavailable to R18 today (7/15/16).

On 7/15/16, at 2:56 p.m. consulting pharmacist (CP) stated he was unaware that R18's temazepam had not been made available to R18. CP confirmed all ordered medications, including the temazepam, should have been filled and made available to R18.

On 7/15/16, at 3:30 p.m. pharmacy technician (PT)-A (from the local pharmacy) verified their pharmacy supplied the medications for the facility. PT-A confirmed R18's prescription for temazepam which had been ordered on 5/12/16, had not been filled due to the pharmacy required a hard copy of the prescription or an electronically ordered prescription for the temazepam. PT-A confirmed the pharmacy had not received from the facility either the hard copy prescription or the electronically signed prescription for R18's temazepam 15 mg.

On 7/15/16, at 3:59 p.m. The ADON stated R18 was admitted to the facility from the hospital and usually the hospital physicians' electronically submitted their prescriptions or sent a hard copy prescription with the resident. When the facility obtained the hard copy prescription, this would then be faxed to the local pharmacy and when the pharmacy brought the medications they would

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21550	Continued From page 52 be given the hard copy prescription. LPN-B confirmed when the pharmacy delivered medications to the facility, the medication nurse signed off that they had received the medications, however, the facility had no medication reconciliation process in place to determine if all medications had been received as ordered. The ADON was unable to explain why R18's temazepam order had not been followed through. On 7/15/16, at 6:00 p.m. nurse consultant (NC) confirmed R18 had not had a sleep pattern assessment completed. Provider Pharmacy Requirements policy dated 5/12, indicated regular and reliable pharmaceutical services would be available to provide residents with prescription and nonprescription medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to assurance that the medication needs of each resident are meet in a timely manner. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A	21615		8/22/16

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21615	Continued From page 53 nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the proper monitoring and security for 5 of 5 emergency medication kits, one which contained narcotic medication. This had the potential to affect all 26 residents residing in the facility who could have potentially required medications/narcotics from the emergency kits. Findings include: On 7/15/16, at 1:31 p.m. during the medication storage tour of the main medication room with licensed practical nurse (LPN)-A, five emergency medication (ekit) storage boxes were observed. These ekit storage boxes were composed of a grey plastic with a clear plastic lid and measured appropximately 18 inches by 24 inches, and three inches in depth. There were labels on the lids of four of the five ekits which identified the contents of each individual ekit (one of the ekits lacked a label). Three of the ekits, one which contained narcotic medications were found stored on top of an automated medication dispensing machine. The other two ekits were in a cabinet with a padlock on the door handles. LPN-A stated she was unaware of the facility's policy for medication storage and monitoring of the ekits which included the narcotic ekit. LPN-A verified the	21615	Corrected.	

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pharmacy which initially had provided the ekits was no longer providing pharmacy services to the facility. LPN-A stated she had recently accessed the ekits on this past Monday, as a resident had an order for an antibiotic. The ekits had not contained the antibiotic the resident required, so LPN-A contacted the pharmacy which currently provided the facility with it's medications. LPN-A verified she would have used the medication from the ekit if it had been available.

On 7/15/16, at 2:35 p.m. the assistant director of nursing (ADON) stated she did not know anything about the ekits. The ADON further stated she did not know if anyone routinely checked the medications for expiration dates, checked the security of the seals on the ekits, or if there were logs used to document the usage of the medications in the ekits. The ADON stated the ekits were there when she started which was about two years ago.

The contents of the ekits were as followed and verified by the director of nursing (DON):

Injectable Emergency Supply Kit -

-Adrenalin (Epinephrine) 1:1000 1 milligrams (mg)(used in life-threatening-allergic reactions) quantity (QTY) 2
-Benadryl 50 mg (antihistamine) QTY 4
-Decadron 4 mg (corticosteriod) QTY 2
-Glucagon Emergency Kit-(controls blood sugar levels) QTY 2
-Haldol 5 mg (antipsychotic) QTY 2
-Heparin-5000 units (blood thinner) QTY 10
-Lasix-10 mg (diuretic) QTY 4
-Lovenox 40 mg (anticoagulant) QTY 2
-Lovenox 100 mg (anticoagulant) QTY 2

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21615	Continued From page 55 -Narcan 0.4 mg (opiate antidote) QTY 2 -Reglan 5mg (gastroesophogeal reflux) QTY 4 -Solu-Medrol 125 mg (corticosteriod) QTY 2 -Visteril 25 mg (antihistamine) QTY 2 -Vitamin K 10 mg (anticoagulant) QTY 2 -Zofran 2 mg (antiemetic) QTY 6 The director of nursing (DON) verified the ekit had seals on the the corners of the kit, which lacked identification numbers and the left seal was broken. The DON verified the medication count was accurate and no medications were expired. The Oral Emergency Supply kit - seal #368210/46011 contained: -Amoxil 250 mg (antibiotic) QTY 10 -Augmentin 500 mg (antibiotic) QTY 10 -Augmentin 875 mg (antibiotic) QTY 10 -Avelox 400 mg (antibiotic) QTY 4 -Bactrim 800 mg (antibiotic) QTY 10 -Catapres 0.1 mg (antihypertensions) QTY 2 -Ceftin 250 mg (antibiotic) QTY 10 -Cipro 250 mg (antibiotic) QTY 10 -Compazine suppository 25 mg (antiemetic) QTY 4 -Coumadin 1 mg (anticoagulant) QTY 1 -Instaglucose 31 grams (gm) (boosts glucose) QTY 2 -Kayexalate 15 gm (treats hyperkalemia) QTY 2 -Keflex 250 mg (antibiotic) QTY 20 -Lasix 20 mg (diuretic) QTY 10 -Levaquin 250 mg (antibiotic) QTY 10 -Macrobid 100 mg (antibiotic) QTY 10 -Nitroquick 0.4 mg (nitrate) QTY 25 -Proventil/Ventolin 0.083% (nebulizer solution) QTY 6 -Vitamin K 5 mg (used for blood coagulation)	21615		

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QTY 2
-Zithromax 250 mg (antibiotic) QTY 6

The DON verified the left seal on the ekit was broken, the medication count was not accurate, four doses of the Proventil/Ventolin were not accounted for and the Kayexalate was not in the kit, and no medications in the ekit were expired.

The Oral Emergency Supply kit Box #0-36, contained seals with no numbers on them. Contents included:

-Amoxil 250 mg (antibiotic) QTY 10 (expired 11/30/15)
-Augmentin 500 mg (antibiotic) QTY 10 (expired 10/18/15)
-Augmentin 875 mg (antibiotic) QTY 10 (expired 8/6/14)
-Avelox 400 mg (antibiotic) QTY 4 (expired 3/2015)
-Bactrim 800 mg (antibiotic) QTY 10 (expired 4/2015)
-Catapres 0.1 mg (antihypertensions) QTY 2
-Ceftin 250 mg (antibiotic) QTY 10 (expired 12/16/14)
-Cipro 250 mg (antibiotic) QTY 10 (expired 8/30/14)
-Compazine suppository 25 mg (antiemetic) QTY 4
-Coumadin 1 mg (anticoagulant) QTY 20 (expired 1/31/15)
-Instaglucose 31 grams (gm) (boosts glucose) QTY 2
-Kayexalate 15 gm (treats hyperkalemia) QTY 2
-Keflex 250 mg (antibiotic) QTY 10 (expired 8/3/14)
-Lasix 20 mg (diuretic) QTY 10 (expired 8/2014)
-Levaquin 250 mg (antibiotic) QTY 10 (expired

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9/2014)
-Macrobid 100 mg (antibiotic) QTY 10 (expired 8/2014)
-Nitroquick 0.4 mg (nitrate) QTY 25 (expired 6/2015)
-Proventil/Ventolin 0.083% (nebulizer solution) QTY 6
-Vitamin K 5 mg (used for blood coagulation) QTY 2 (expired 10/11/14)
-Zithromax 250 mg (antibiotic) QTY 6 (expired 10/11/14)

The DON verified all of the medication with the exception of the Catapres, Compazine, Instaglucose and Kayexalate had expired dates, in addition, the medication count was not accurate. The inventory list taped to the top of the ekit, indicated there should have been 10 doses of the Macrobid 100 mg and the ekit only contained nine doses (one dose of Macrobid unaccounted for).

Medication Ekit seal tags #368213/368279 did not have a contents list on the lid. The ekit contained:

-Benadryl 50 mg (antihistamine) QTY 4 vials
-Decadron 4 mg (corticosteriod) QTY 2 vials
-Adrenalin (Epinephrine) 1:1000 1 milligrams (mg)(used in life-threatening-allergic reactions) QTY 2 vials
-Haldol 5 mg (antipsychotic) QTY 2 vials
-Heparin-5000 units (blood thinner) QTY 9 vials
-Lasix-10 mg (diuretic) QTY 4 vials
-Narcan 0.4 mg (opiate antidote) QTY 2 vials
-Reglan 5mg (gastroesophogeal reflux) QTY 4 vials
-Solu-Medrol 125 mg (corticosteriod) QTY 2 vials
-Visteril 25 mg (antihistamine) QTY 2 vials

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(expired 5/2016)
-Vitamin K 10 mg (anticoagulant) QTY 2 vials (expired 5/1/16)
-Zofran 2 mg (antiemetic) QTY 6 vials
-Lovenox 40 mg (anticoagulant) QTY 2 syringes
-Lovenox 100 mg (anticoagulant) QTY 2 syringes
-Glucagon Emergency Kit-(controls blood sugar levels) QTY 2 kits

The DON verified the ekit lacked a pharmacy content label on the cover, therefore they were not able to verify if the medication count was accurate. In adidtion, verified the ekit contained two expired medications, the Visteril 25 mg and Vitamin K 10 mg.

The Narcotic Emergency Supply ekit- seal # 429430/429436 contents included:

-Ativan 0.5mg QTY 6
-Ativan 2 mg injection QTY 2
-Dilaudid 2 mg QTY 6
-Morphine sulfate injection 10 mg QTY 4
-Morphine sulfate suppository 5 mg. QTY 4
-Oxycodone 5mg QTY 6
-Percocet 5/325 mg QTY 6
-Morphine sulfate oral solution 10 mg QTY 6
-Tylenol # 3 300mg/30 mg QTY 6
-Valium Injection 5mg QTY 2
-Vicodin tablets 5/500 mg QTY 6

The DON verified the narcotic ekit contained narcotic medications and the narcotic medication count was inaccurate. Medications which were unaccounted for included: (with discrepancies included:)

-Vicodin tablets 5/500 mg QTY 6
-Valium Injection 5mg QTY 2

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21615	Continued From page 59 -Morphine sulfate oral solution 10 mg QTY 6 -Morphine sulfate suppository 5 mg. QTY 4 -Ativan 2 mg injection QTY 2 The DON verified the above noted medications were unaccounted for. On 7/15/16, at 2:40 p.m. the DON stated she was unaware that the ekits existed, or that staff had attempted to utilize the medications out of the ekits. The DON verified the nurses should have been routinely ensuring the ekits were secured with the required seals, were stored appropriately to ensure the security of the medications, and the medications should have been monitored for expiration dates and reconciled. The DON stated the ekit storage system and lack of monitoring was a concern and she would expect staff to be monitoring them daily, and the narcotic medications should have been double locked. On 7/15/16, at 2:58: p.m. the consulting pharmacist (CP) stated he checked the facility's medication storage room on a quarterly basis. The CP stated he would have included any recommendations regarding ekits monitoring and storage on his report to the facility, but does not recall making any recommendations for the ekits. The CP verified proper monitoring and storage of ekits was something he looked for, including use of ekit medications and expiration dates of the medications. The CP stated he would expect the facility to monitor the use of ekit medications and the seals on a daily basis, especially the controlled (narcotic) medications. The CP stated he was unaware the facility's medication storage room contained these five ekits of medication. CP confirmed he had missed this and it would have	21615		

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been something that he should have included in his review of the medication storage process at the facility.

Emergency Pharmacy Service and Emergency Kits policy, dated 5/12, indicated the emergency supply was maintained at a designated area, along with a list of supply contents and expirations dates, the nurse records the medication use from the emergency kit on the medication form and flags the kit with a color-coded lock to indicate need for replacement. The kits are monitored/inventoried by the consultant pharmacist/provider pharmacy at least every 30 days for completeness and expiration dating of the contents.

Accountability for controlled substances stored in the emergency kit is maintained as follows: a perpetual inventory system is used with a separate sheet or a bound book with numbered pages for each individual medication in the kit. Each dose given and all replacement doses received from the pharmacy are entered on the appropriate inventory sheet with the "Amount Remaining" adjusted accordingly. The incoming and outgoing nurses verified the inventory of controlled substances at each change of shift or exchange of keys.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) and pharmacist or their designee, could develop and implement policies/procedures and staff training related to medication storage. The quality assessment and

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21615	Continued From page 61 assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21615		
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 and document review, the facility failed to ensure attempts to form a family council were conducted in the last calendar year, as required. Findings include: On 7/13/2016, at 8:57 a.m. the social worker (SW) verified there was not a family council at the facility and there had been no formal attempts to	21942	Corrected.	8/22/16

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21942	Continued From page 62 form a family council since she began working at the facility five months ago. The SW stated she had no information regarding any previous attempts at forming a family council and was unaware that one of her responsibilities was to facilitate the formation of a Family Council for the facility. On 7/15/16, at 9:14 a.m. the administrator verified the facility should have attempted to form or arrange a family council and or a meeting annually. The facility policy, Family Council dated 2/4/16, indicated a family council would be developed to serve as a mechanism for promoting communication, education, and support between members and staff. The expectation was to coordinate a Family Council meeting at least quarterly. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or their designee could develop and implement policies and procedures related to the formation of a Family Council. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	21942		