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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZK82

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00989

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245097**

2.STATE VENDOR OR MEDICAID NO.
(L2) **332668000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FARIBAULT CARE CENTER**
(L4) **1738 HULETT AVENUE NORTH**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2013** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 03/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 04/08/2013 (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
01/12/1967
(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.
00320
(L31)

30. REMARKS
POSTED 4/29/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2013
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5097

At the time of the standard survey completed February 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On March 19, 2013, the Minnesota Department of Health and, on March 13, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 1, 2013, effective March 13, 2013. Therefore, the remedies outlined in our letter dated February 20, 2013, will not be imposed. See attached CMS-2567B forms for the results of the March 19, 2013 and March 13, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5097 April 8, 2013

Ms. Brenda Schrupp, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

Dear Ms. Schrupp:

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 March 13, 2013 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2013

Ms. Brenda Schrupp, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

RE: Project Number S5097023

Dear Ms. Schrupp:

On February 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 1, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 13, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 1, 2013, effective March 13, 2013 and therefore remedies outlined in our letter to you dated February 20, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5097r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245097	A. Building B. Wing	3/19/2013

Name of Facility	Street Address, City, State, Zip Code
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **03/13/2013**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/13/2013**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/13/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0320** Reg. # **483.25(f)(2)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/13/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/13/2013**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **03/13/2013**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/sd	03/20/13	16022	03/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245097	A. Building B. Wing	3/19/2013

Name of Facility	Street Address, City, State, Zip Code
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **03/13/2013**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/sd	03/19/13	16022	03/19/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/1/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245097	A. Building B. Wing 01 - MAIN BUILDING 01	3/13/2013

Name of Facility	Street Address, City, State, Zip Code
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 01/30/2013	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 02/18/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/sd	Date: 03/20/13	Signature of Surveyor: 25822	Date: 03/13/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/29/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZK82

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00989

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245097**

2.STATE VENDOR OR MEDICAID NO.
(L2) **332668000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FARIBAULT CARE CENTER**
(L4) **1738 HULETT AVENUE NORTH**
(L5) **FARIBAULT, MN** (L6) **55021**

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) **01/01/2011**

6. DATE OF SURVEY **02/01/2013** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Nadine Olness, HFE NE II 03/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/20/2013 (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
01/12/1967
(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.
00320
(L31)

30. REMARKS
Posted 3/22/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5097

At the time of the standard survey completed February 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6164

February 20, 2013

Ms. Brenda Schrupp, Administrator
Faribault Care Center
1738 Hulett Avenue North
Faribault, Minnesota 55021

RE: Project Number S5097023

Dear Ms. Schrupp:

On February 1, 2013, 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. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 13, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

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 May 1, 2013 (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 August 1, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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:

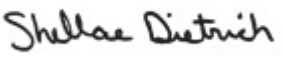
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5097s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245097	A. BUILDING _____ B. WING _____	02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARIBAULT CARE CENTER	1738 HULETT AVENUE NORTH FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This plan of correction is submitted as required under Federal and State laws. The submission of this Plan of Correction does not constitute an admission on the part of Faribault Care Center as to the accuracy of the surveyors' findings or the conclusions drawn there from. The Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on this basis. The Facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney, or shareholder of the Facility or affiliated companies.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225 3/4/13 SER		3/13/13

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

Administrator 3/1/13

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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 2 of 6 residents (R23, R43) in the sample who reported allegations of abuse. In addition, the facility failed to ensure these residents were protected from potential retaliation while an investigation was pending. Findings include: R43 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agencies. On 1/30/13, at 7:30 a.m. a nursing assistant (NA) -B stated about a month ago, when she was providing morning peri care for	F 225	F225 Initial investigation on R43 completed on 1/14/13. Initial investigation on R23 completed on 1/30/13. In addition to initial investigations, all residents were interviewed regarding staff treatment and all staff members were interviewed regarding the VA policy on 1/30/13. Policy regarding Abuse Prevention Plan will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 5 random audits will be completed per week with residents to ensure proper staff treatment. 2. 5 random audits will be completed per week to ensure staff are knowledgeable on Abuse Prevention Policy.	

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F 225	Continued From page 2 R43, the resident stated "don't you do to me what that guy did last night." When NA-B inquired further R43 stated "he stuck his finger in my ass." NA-B stated the resident did not identify a staff member by name however, there was only one staff member working in the memory care unit on the night shift and it happened to be a male. NA-B stated she immediately reported the incident to her supervisor and when she came to work the following morning she was shocked to see the nursing assistant (NA)-C who had been accused of potential abuse was allowed to work with the residents on the secured memory care unit where there are no other staff present on the night shift. R43 had diagnoses of cognitive deficits related a stroke and was legally blind. R43's annual Minimum Data Set (MDS) dated 12/28/12 indicated the resident had moderately impaired cognition and no behavior symptoms. The MDS indicated R43 required extensive assistance with bed mobility and was totally dependent on staff for assistance with transfers, dressing, personal hygiene and toileting. The MDS indicated R43 was frequently incontinent of bowel and bladder. R43's care plan, revised on 12/14/12, indicated the resident was a vulnerable adult and was at risk for maltreatment related to impaired cognition. The care plan indicated the resident displays physical and verbal behavior symptoms when his needs were not immediately met or when he is startled by others. The care plan indicated the resident makes inappropriate sexual comments to staff; however, it did not describe the nature of these comments. The care plan did not identify a problem with making false	F 225	3. 1 investigation will be randomly audited per week to ensure investigation is thorough and completed per Abuse Prevention Policy. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: March 13, 2013 RECEIVED MAR 04 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 225	Continued From page 3 accusations regarding staff. Review of the incident investigation documentation revealed the director of nursing (DON) was informed of the incident on 1/13/13 (no time). On 1/13/13, at 10 p.m. NA-C was interviewed regarding the allegation at the start of his shift by registered nurse (RN)-A. The documentation indicated NA-C was informed of the allegation and he denied the accusation. NA-C was allowed to work his shift that night and was directed to call for assistance when R43 needed care and staff from the long term care side of the building would come over to assist him. There was no further evidence of an investigation until 1/14/13, at 12:30 p.m. when the DON interviewed one other nursing assistant (NA)-D, NA-B and R43. The investigation was determined to be inconclusive on 1/14/13 and NA-C was reminded to call for assistance with R43 if the resident is combative or yelling. Although the resident reported an incident of alleged abuse, the facility failed to complete a thorough investigation of the allegation that included additional interviews with other residents who had contact with NA-C and interviews with other employees who had worked with NA-C. Although the incident reportedly occurred on the night shift beginning on 1/12/13 and ending in the early morning on 1/13/13, NA-C was allowed to work his scheduled shift in the secured memory care unit while the investigation results were pending. Furthermore, the documentation provided lacked evidence to indicate the facility's administrator, the Minnesota Department of Health (MDH) and the Common Entry Point (CEP) were immediately informed of the	F 225		

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F 225	Continued From page 4 allegation of potential abuse. On 1/30/13, at 2:10 p.m. the DON confirmed she conducted an investigation of the allegation and determined the allegation was inconclusive on 1/14/13 at approximately 5:30 p.m. The DON confirmed NA-C had worked with the resident's on the memory care unit while the investigation results were still pending. The DON stated NA-C worked in both the secured memory care unit and the long term care unit within the facility and that he usually works the night shift and occasionally the afternoon shift. When asked if she had interviewed any other residents or staff in the building regarding the care and treatment provided by NA-C she replied, she had interviewed one other nursing assistant (NA)-D and no additional residents. When asked if there were any other resident's in the memory care unit that she could have interviewed regarding the care they received from NA-C she replied, "yes, one other resident in the unit would have been able to tell me if something was happening." The DON was asked if the administrator was notified and she replied, "yes, on the same day I was." However, the DON could not recall who had informed the administrator. She thought it may have been herself or the nurse who had originally reported the incident. The DON confirmed the documentation did not reveal if or when the facility's administrator was notified regarding the incident and stated she did not report the incident to the CEP or MDH. When asked if the resident had a history of making false accusation regarding staff the DON replied, "not that I am aware of." The DON confirmed the care plan did not indicate this was a problem for the resident. The DON later confirmed the facility was not	F 225		

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F 225	Continued From page 5 monitoring the resident for this type of behavior. The DON confirmed the resident's medical record lacked evidence of the incident/allegation. The DON was asked to explain the facility's policy/procedure regarding protection of residents when allegations of abuse a reported to staff. The DON could not recite the facilities procedure and had to look at the policy to gain the information. The DON confirmed the facilities policy indicated that when allegations of potential abuse are made known to staff, the alleged perpetrator should be removed from direct contact with residents until the investigation is complete. When asked if the facility's policies were followed regarding investigating, reporting, and protection of residents who report allegations of abuse she replied, "No." On 1/31/13, at 2:35 p.m. a licensed practical nurse (LPN)-A, stated she reported the above incident to the DON on the morning she learned of the allegation (1/13/13). LPN-A stated she did not inform the administrator of the incident, the resident is reliable "to some extent," she had never heard the resident make an allegation like this before and she did not examine the resident for any signs of injury when the allegation was reported to her. R23 verbalized concerns regarding cares provided by a nursing assistant (NA)-E. The facility failed to thoroughly investigate the concerns. During an initial resident interview on 01/28/13, at 5:03 p.m. R23 reported that a nursing assistant NA-E did not treat her right, "she tells me to move faster and I try, but can't. It hurts my feelings. She	F 225		

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F 225	Continued From page 6 doesn't like me." R23 stated NA-E told her that she mumbled. R23 said, "She just doesn't like me and I don't know why. She likes other residents and is nice to them." R23 stated she had not reported these incidents to anyone and she would talk to the nurse manager about it. On 01/28/13, at 7:35 p.m. the director of nursing (DON) was informed that R23 had some concerns regarding a staff member. On 01/30/13, at 3:10 p.m. the DON provided a copy of investigative findings, which included interviews with R23, the DON and three additional staff members. On 01/28/13, at 7:45 p.m. the social worker initially interviewed R23. R23 reported NA-E was very abrupt with her during the morning care. R23 stated that NA-E didn't like to pull up her pants and wanted R23 to pull her pants up on her own. R23 reported that NA-E tells her to move faster in the hallway when going to the dining room and added, "She makes me nervous." On 01/28/13, R23 reported to the DON that NA-E was "abrupt" and "rude" to her. R23 reported that NA-E wanted her to pull up her depend and pants on he own from the back, which she was unable to do. R23 reported that NA-E has treated her this way since her admission to the facility. R23 indicated that other care givers were not like NA-E. R23 indicated that she did not want NA-E to assist her. The DON interviewed NA-E on 01/28/13 and nothing unusual was reported, the morning cares went fine. DON removed NA-E from the schedule pending investigation and was called into work	F 225		

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F 225	Continued From page 7 the next shift. On 01/29/13, two nursing assistants (NA)-F and (NA)-G and a licensed practical nurse (LPN-B) were interviewed. NA-B and LPN-B reported that they had not heard any concerns expressed by R23 regarding NA-E. However, NA-G reported that one time R23 asked her why NA-E did not like her. NA-G asked R23 why she felt that NA-E did not like her and R23 responded because she made her do things. NA-G indicated that she did not remember when this happened. There was no documentation regarding whetherr NA-G had reported R23's concern to the charge nurse. On 01/29/13, the DON spoke with R23 about the findings and asked R23 if she felt that NA-E was being mean or abusive toward her. R23 responded, "no, just abrupt," she made her do things. R23 again stated that she did not want NA-E to help her. Based on these interviews the DON concluded no evidence of abuse and the staff was following therapies instructions, the "Resident does not care for staff member's strong persistence with independence." NA-E returned to work and was instructed not to provide cares to R23. The facility did not interview any additional residents to gain understanding of NA-E's work habits and potential concerns related to her refusing to assist, rushing, being rude and abrupt with other residents. In an interview with DON on 01/30/13, at 3:10 p.m. the DON stated she did not interview other residents and it would have been beneficial to talk to other residents to find out if they had any	F 225		

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F 225	Continued From page 8 concerns with NA-E.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement established policies and procedures to protect residents who reported allegations of potential abuse, thoroughly investigate allegations of abuse and immediately report allegations of potential abuse to the facility's administrator and state agencies for 2 of 6 residents (R23, R43) in the sample who reported allegations of abuse. Findings include: R43 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agency. Review of the facility's Abuse Prevention Plan updated 7/13/12, revealed allegations of abuse must be reported immediately to the facility's administrator, the CEP and MDH. The policy directed staff to complete a physical examination immediately upon receiving an allegation of	F 226	F226 Initial investigation on R43 completed on 1/14/13. Initial investigation on R23 completed on 1/30/13. In addition to initial investigations, all residents were interviewed regarding staff treatment and all staff members were interviewed regarding the VA policy on 1/30/13. Policy regarding Abuse Prevention Plan will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 5 random audits will be completed per week with residents to ensure proper staff treatment.	3/13/13

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

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F 226	Continued From page 9 physical or sexual abuse. The policy indicated if a staff member is accused or suspected of abuse, that staff member will be removed from direct resident contact until an investigation is complete. The policy indicated written statements will be obtained from the resident (if possible), the accused and all witness' regarding the incident. The policy defined a witness as anyone who may have been in close contact with the resident and any employees who had worked closely with the accused employee and the alleged victim on the day of the incident. On 1/30/13, at 7:30 a.m. a nursing assistant (NA) -B stated about a month ago, when she was providing morning peri care for R43, the resident stated "don't you do to me what that guy did last night." NA-B stated she immediately reported the incident to her supervisor and when she came to work the following morning she was shocked to see the nursing assistant (NA)-C who had been accused of potential abuse was allowed to work with the residents on the secured memory care unit where there are no other staff present on the night shift. Review of the incident investigation documentation revealed the director of nursing (DON) was informed of the incident on 1/13/13 (no time). On 1/13/13, at 10 p.m. NA-C was interviewed regarding the allegation at the start of his shift by registered nurse (RN)-A. The documentation indicated NA-C was informed of the allegation and he denied the accusation. NA-C was allowed to work his shift that night and was directed to call for assistance when R43 needed care and staff from the long term care	F 226	2. 5 random audits will be completed per week to ensure staff are knowledgeable on Abuse Prevention Policy. 3. 1 investigation will be randomly audited per week to ensure investigation is thorough and completed per Abuse Prevention Policy. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 226	Continued From page 10 side of the building would come over to assist him. There was no further evidence of an investigation until 1/14/13, at 12:30 p.m. when the DON interviewed one other nursing assistant (NA)-D, NA-B and R43. The investigation was determined to be inconclusive on 1/14/13 and NA-C was reminded to call for assistance with R43 if the resident is combative or yelling. Furthermore, the documentation provided lacked evidence to indicate the facility's administrator, the Minnesota Department of Health (MDH) and the Common Entry Point (CEP) were immediately informed of the allegation of potential abuse. On 1/30/13, at 2:10 p.m. the DON confirmed she conducted an investigation of the allegation and determined the allegation was inconclusive on 1/14/13 at approximately 5:30 p.m. The DON was asked if the administrator was notified and she replied, "yes, on the same day I was." However, the DON could not recall who had informed the administrator. She thought it may have been herself or the nurse who had originally reported the incident. The DON confirmed the documentation did not reveal if or when the facility's administrator was notified regarding the incident and stated she did not report the incident to the CEP or MDH. When asked if the facility's policies were followed regarding investigating, reporting, and protection of residents who report allegations of abuse she replied, "No." On 1/31/13, at 2:35 p.m. a licensed practical nurse (LPN)-A, stated she reported the above incident to the DON on the morning she learned of the allegation (1/13/13). LPN-A stated she did not inform the administrator of the incident, the resident is reliable "to some extent," she had	F 226		

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F 226	Continued From page 11 never heard the resident make an allegation like this before and she did not examine the resident for any signs of injury when the allegation was reported to her. 23's reported an allegation regarding rude and abrupt treatment by staff and the facility failed to thoroughly investigate as directed by the facility's Abuse Prevention Plan. During an initial resident interview on 01/28/13, at 5:03 p.m. R23 reported that a nursing assistant NA-E did not treat her right. On 01/28/13, at 7:35 p.m. the director of nursing (DON) was informed that R23 had some concerns regarding a staff member. On 01/30/13, at 3:10 p.m. the DON provided a copy of investigative findings, which included interviews with R23, the DON and three additional staff members. The DON interviewed NA-E on 01/28/13, who reported nothing unusual and stated R23's morning cares went fine. DON removed NA-E from the schedule pending investigation and was called into work the next shift. On 01/29/13, two nursing assistants (NA)-F and (NA)-G and a licensed practical nurse (LPN-B) were interviewed. NA-B and LPN-B reported that they had not heard any concerns expressed by R23 regarding NA-E. However, NA-G reported that one time R23 asked her why NA-E did not like her. NA-G asked R23 why she felt that NA-E did not like her and R23 responded because she made her do things. NA-G indicated that she did not remember when this happened. There was	F 226		

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F 226	Continued From page 12 no documentation regarding weather NA-G had reported R23's concern to the charge nurse. On 01/29/13, the DON spoke with R23 about the findings and asked R23 if she felt that NA-E was being mean or abusive toward her. R23 responded, "no, just abrupt," she made her do things. R23 again stated that she did not want NA-E to help her. Based on these interviews the DON concluded no evidence of abuse and the staff was following therapies instructions, the "Resident does not care for staff member's strong persistence with independence." NA-E returned to work and was instructed not to provide cares to R23. The facility did not interview any additional residents to gain understanding of NA-E's work habits and potential concerns related to her refusing to assist, rushing, being rude and abrupt with other residents. In an interview with DON on 01/30/13, at 3:10 p.m. the DON stated she did not interview other residents and it would have been beneficial to talk to other residents to find out if they had any concerns with NA-E.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accommodate the needs of 1 of 1 resident (R20) whose mattress was not long enough. Findings include: The facility failed to ensure that R20's bed size was appropriate for his height. R20's height was seventy-eight inches. The mattress was measured by the maintenance director on 2/1/13, at 12:00 p.m. and determined to measure seventy-two inches in length. R20 had diagnosis of diabetes mellitus, osteoarthritis, hypertension, and morbid obesity. R20 chose to spend most of the day in bed. The Brief Interview of Mental Status indicated the resident was cognitively intact. A Braden pressure risk assessment dated 11/18/12, indicated R20's sensory perception was slightly limited, can't always communicate discomfort or the need to be turned. Moisture: skin is occasionally moist requiring an extra linen change approximately every day. Activity: resident is confined to bed, Mobility: very limited, makes occasional slight changes in body or extremity position but unable to make frequent or significant changes in body or extremity position. Friction and shear: problem, requires moderate to maximum assistance in moving, complete lifting without sliding against sheets is impossible, frequently slides down in bed or chair, requiring frequent reposition with maximum assist. The	F 246	F246 A new mattress was obtained for R20. Policy regarding Quality of Life – Accommodation of Needs will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. Whole house audit will be completed to ensure all residents have a proper fitting mattress. 2. All new admissions will be audited to ensure a proper fitting mattress is provided. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: March 13, 2013	3/13/13

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F 246	Continued From page 14 assessment indicated R20 is at moderate risk for the development of pressure ulcers. On 1/29/13, at 10:00 a.m. R20's feet and legs were observed to be propped on two pillows for each leg. The resident stated he was informed by the facility at the last two care conferences and from both his old and new doctor that his bed was too small for him. R20's legs were resting on top of the foot board and feet were hanging over the foot board approximately six inches off the mattress. The resident stated he has always needed an extra long bed. On 1/30/13, at 10:40 a.m. R20 was observed lying in bed with his legs resting on the foot board and feet hanging over the foot board of the bed. R20 had two pillows propped under each leg. He stated, he had requested to be repositioned and was waiting for the nursing assistant to return. At 10:45 a.m. two nursing assistants entered the resident's room to reposition him. After R20 was repositioned in bed his feet were observed to be hanging over the foot board and his legs resting on the foot board approximately six inches with two pillows propped under each leg. On 1/31/13, at 8:15 a.m., R20 was observed to be in bed eating breakfast with his feet hanging off the mattress approximately six inches and legs were propped on two pillows under each leg. During review of care conference notes and physician progress notes there was no indication that R20's bed mattress had been discussed. The social worker was interviewed on 1/31/13, at 2:00 p.m. and stated that R20 did not inform staff during care conferences of his bed needs. On 1/31/13, at 4:00 p.m. the director of nursing	F 246		

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F 246	Continued From page 15 stated during the preadmission screening process for a new resident they receive a report from the previous facility which includes the residents height and weight. We than consult with our medical supply company to determine if the size of the bed is appropriate for the new resident. We own some of our beds and rent the others. We also assess after the residents arrival to determine proper fit. During review of the medical record there was no documentation indicating that this procedure was completed. The facilities Qaulity of Life-Accommodation of Needs policy, dated 2/1/13, indicated the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the resident or other residents would be endangered. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide an individualized activity program designed to meet	F 248	F248 R26 Activity Assessment and Care Plan will be reviewed and updated to reflect individualized activity preferences. Policy regarding Activity Assessment and Activity Programs will be reviewed and updated by Administrator or designee. All staff who work on Memory Lane will be educated on policies by Activity Director or designee.	3/13/13

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F 248	Continued From page 16 the needs and interests for 1 of 4 residents (R26) in the sample who was cognitively impaired and dependent on staff for assistance with activity programming. Findings include: R26's annual Minimum Data Set (MDS) dated 10/19/12 indicated the resident had severely impaired cognition and required extensive assistance with activities of daily living. The assessment indicated the Daily and Activity Preferences resident interview could not be completed by the resident, family member or significant other. The Staff Assessment of Daily and Activity Preferences indicated the resident did not prefer snacks between meals, staying up past 8:00 p.m., family or significant other involvement in care discussions, reading books, newspapers,or magazines, listening to music, being around animals such as pets, keeping up with the news, participating in favorite activities, spending time outdoors, doing things with groups of people and participating in religious activities or practices. The Activities Evaluation dated 9/27/12 indicated R26 formerly worked for a local newspaper and found strength in their catholic faith. The evaluation identified the following current interests: animals/pets, arts/crafts, movies, music/radio, sing along's, cooking/baking, current events/news and social parties. The evaluation indicated R26 is cooperative, enjoys looking through books, news papers, watching television, the resident's family is involved and R26 has a sibling who also resides in the facility. The Quarterly Activities Assessment dated 12/31/12	F 248	Re-occurrence will be prevented by the Activity Director or designee completing the following audits: 1. Audit will be completed to ensure all residents on Memory Lane have a comprehensive activity assessment and care plan. 2. 5 random audits will be completed per week to ensure scheduled/individualized activities are being completed on Memory Lane. All information will be brought to QA by Activity Director to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 248	Continued From page 17 also indicated R26's family was involved. The Activities Care Area Assessment (CAA) dated 10/19/12 indicated activities was an actual problem for R26. The CAA indicated that prior to admission R26 preferred group activities and the resident's socially inappropriate behavior reduced participation in activities. The CAA concluded there had been co changes in R26's activity programming needs and the current plan of care will be continued with a goal to maintain the resident's current level of function. R26's care plan, revised on 4/19/12, indicated the resident required assistance and encouragement to engage in leisure activities and unit programming due to their cognitive impairment. The care plan directed staff to encourage R26 to help with small tasks in the unit, observe for changes in mood and cognition, staff will escort R26 outdoors as the resident desires, staff will invite and encourage me to participate in meaningful activity, staff will escort to and from activities as needed, ensure the resident has glasses on during activities, staff will provide an activity calendar, staff will provide me with newspapers and any other activity supplies. The care plan directed staff to encourage the resident to participate in meaningful activities but, failed to indicate what activities would be meaningful to the resident other than wandering. The Memory Lane nursing assistant assignment sheet updated 1/28/12, failed to identify the resident's activity interests and needs. Review of the Memory Lane activity calendar for January 2013 identified the units daily activity schedule which began daily at 10:00 a.m. and	F 248		

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F 248	Continued From page 18 ended with the last activity of the day at 6:30 p.m. The activity programing was consistent in that every morning at 10:00 a.m., the activity listed was Morning Television, at 11:15 a.m. Individual Activities, at 1:15 p.m. Afternoon Music/Game,at 3:30 p.m. Afternoon Game and at 6:30 p.m. Sensory Activity in addition to others. The calendar indicated there were weekly church services on Thursdays. The resident was not observed to participate in any activities during stage one of the survey. On 1/31/13, at 9:25 a.m. R26 was observed sitting alone at the dining table in the dining room facing the wall. She did not have a newspaper or book near her. There were no activities occurring in the unit other than the television on in the day room. On 1/31/13, at 10:20 a.m. the resident was observed standing in the middle of her room with the door closed. There was no music or television on in the resident's room. On 1/31/13, at 9:25 a.m. the nursing assistant (NA)-B working in the memory care unit was interviewed regarding the activity programing in the unit. NA-B states the activities provided in the memory care unit are mostly 1:1 activities. NA-B provided R26's Memory Lane Resident Activity Participation Form dated January 2013 for review. The flowsheet indicated the resident had not participated in a single activity since January 24, 2013. When questioned further regarding the activity programming in the unit NA-B stated the nursing assistant working in the unit is supposed to also complete the activity programming for the resident's in the unit. The resident's participation in activities is then recorded on the flowsheet. NA-B verified there were no activities	F 248		

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F 248	Continued From page 19 documented on R26's January 2013 flowsheet. Although R26's Activity Evaluation identified current interests of arts/crafts, baking, radio/music, social/special events and pet visits review of Memory Lane Resident Activity Participation Forms dated October 2012 through January 2013 indicated the resident did not participate in a arts/crafts, baking, radio/music, social/special event during this time period. The Activities Evaluation indicated the resident found strength their catholic faith; however, the resident attended church only one time during the four month period. On 1/31/13, at 9:32 a.m. the facility's Activities Director (AD) was interviewed regarding the activity programming in the memory care unit. The AD stated, the nursing assistants who work in the memory care unit are responsible for providing the daily scheduled activities. The AD stated there is a whole closet full of activities appropriate for residents who reside in the memory care unit. The AD verified R26's Memory Lane Resident Activity Participation Form for the month of January 2013 indicated the resident had not attended any activities since January 24, 2013 and stated "if it is not documented it is not done." The AD added the facility has had an ongoing problem with activity programming and documentation. The AD stated the staff on the memory care unit are to follow the activity calendar schedule. When asked who is supposed to monitor the activity flowsheets to ensure the activity programming is getting done, the AD replied, "I am." When asked how one nursing assistant is supposed to tend to the needs of 12 potential resident's while performing "individual	F 248		

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F 248	Continued From page 20 activities" for a resident. She replied, "I know what you mean."Ideally they should be performing group activities. On 2/1/13, at 11:27 a.m. there were five resident's sitting in the dining room and two sitting in wheelchairs in the hallway. The television was on in the day room however, no one was in the room at the time. There were no other activities occurring in the unit. R26 was sitting in a chair in the dining room and did not have a book, magazine or newspaper near her. On 2/1/13, at 11:37 a.m. NA-B was interviewed regarding activity programming in the unit. NA-B was asked if she had completed the individual activities that were scheduled at 11:15 a.m. with any of the resident's in the unit. NA-B replied, she had not. When asked what activities R26 liked to participate in NA-B replied the resident enjoys to look at the newspaper and books. NA-B stated R26 used to have a binder in her room that she enjoyed looking at however, she has not seen this in "a long time." NA-B looked through R26's room for the binder and was unable to locate it. When asked if she had enough time to complete the daily activities that were scheduled in the unit NA-B replied, "no", and said it had been brought to the attention of the management staff. On 2/1/13, at 11:42 a.m. a male resident was sitting in his wheelchair in the hallway. When asked by staff if he wanted to go into the dining room he said, "what for we will just sit there and do nothing anyway."	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		

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F 253	Continued From page 21 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a clean and sanitary environment in the memory care unit where 2 of 4 pieces of furniture in the common area were heavily soiled and in need of cleaning. This had the potential to affect all 10 of the residents who resided in the memory care unit of the 43 residents who resided in the facility. In addition, 2 of 16 rooms on the 300 wing had soiled furniture and appliances. Findings include: During the initial tour of the memory care unit on 1/28/12, at 12:00 p.m. a lounge chair in the day room was heavily soiled with a black/brown substance. During the environmental tour of the facility on 1/31/13, at 11:00 a.m. a green love seat in the memory care unit was observed with a large, dried, black stain on the left side by the seat along with other surrounding areas of grayish brown stains. The arm rests and seat cushions on the matching couch and chair also had many spotted soiled areas. A large lounge chair in a residents room on the 300 wing was heavily soiled and a refrigerator in a residents room had black and brown stains and spots throughout the refrigerator. On 1/31/13, at 11:00 a.m. the administrator and maintenance supervisor agreed the furniture was soiled and in need of cleaning. The housekeeping	F 253	F253 All furniture on Memory Lane, Personal Recliner for resident on 300 wing, and Personal Refrigerator for resident were cleaned. Routine schedules developed for cleaning of furniture and personal appliances. Policy regarding Cleaning/Repairing Carpeting and Cloth Furnishings and Personal Appliances will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. Whole house audit will be completed to inventory all furniture and personal appliances. 2. 5 Random audits will be completed per week to ensure furniture and/or personal appliances are cleaned properly.	3/13/13

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F 253	Continued From page 22 supervisor indicated there were no systems in place to monitor for soiled furniture and agreed the furniture needed cleaning. On 2/1/13, at 3:40 p.m. the maintenance supervisor stated housekeeping staff should be cleaning personal furniture and resident refrigerators when soiled.	F 253	All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: March 13, 2013	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive plan of care for 1 of 4 residents (R26) in the sample who	F 279	F279 R26 Activity Care Plan will be reviewed and updated. R22 Expired on 12/4/12. Policy regarding Care Plans – Comprehensive will be reviewed and updated by Director of Nursing or designee. All staff responsible for care planning will be educated on policy by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to ensure all residents have a comprehensive activity care plan.	3/13/13

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F 279	Continued From page 23 was dependent on staff for activity programming needs and 1 of 5 residents (R22) in the sample who required assistance with activities of daily living. Findings Include: R26 had severe cognitive impairments and was dependent on staff for activity programming needs. R26's activity care plan failed to identify the resident's current interests and activities that were appropriate for the resident to participate in. The Activities Evaluation dated 9/27/12 indicated R26 formerly worked for a local newspaper and found strength in catholic faith. The evaluation identified the following current interests: animals/pets, arts/crafts, movies, music/radio, sing along's, cooking/baking, current events/news and social parties. The evaluation indicated R26 is cooperative, enjoys looking through books, news papers, watching television, the resident's family is involved and R26 has a sibling who also resides in the facility. The Activities Care Area Assessment (CAA) dated 10/19/12 indicated that prior to admission R26 preferred group activities and the resident's socially inappropriate behavior reduced their participation in activities. The CAA concluded there had been no changes in R26's activity programming needs and the current plan of care will be continued with a goal to maintain the resident's current level of function. R26's care plan, revised on 4/19/12, indicated the resident required assistance and encouragement to engage in leisure activities and unit programming due to cognitive impairment. The care plan directed staff to encourage R26 to help	F 279	2. Whole house audit will be completed to ensure all residents have a comprehensive ADL care plan. 3. All new admissions will be audited to ensure they have a comprehensive activity care plan. 4. All new admissions will be audited to ensure they have a comprehensive ADL care plan. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 279	Continued From page 24 small tasks in the unit, observe for changes in mood and cognition, staff will escort R26 outdoors as the resident desires, staff will invite and encourage R26 to participate in meaningful activity, staff will escort to and from activities as needed, ensure the resident has their glasses on during activities, staff will provide an activity calendar, staff will provide R26 with newspapers and any other activity supplies. The care plan directed staff to encourage the resident to participate in meaningful activities but, failed to indicate what activities would be meaningful to the resident other than wandering. The Memory Lane nursing assistant assignment sheet updated 1/28/12, failed to identify the resident's activity interests and needs. Although R26's activity evaluation identified the resident's current interests, review of Memory Lane Resident Activity Participation Forms dated October 2012 through January 2013 indicated the resident did not go outside or participate in a arts/crafts, baking, radio/music, social/special event during this time period. In addition, the Memory Lane Resident Activity Participation Form dated January 2013 indicated the resident had not participated in any activities at all since January 24, 2013. On 1/31/13, at 9:32 a.m. the facility's Activities Director (AD) verified these findings and stated "if it is not documented it is not done." R22's was dependent on staff for assistance with activities of daily living (ADLs) and the medical record lacked evidence of a ADL care plan that identified the interventions required to meet those needs.	F 279		

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F 279	Continued From page 25 R22 was admitted to the facility on 09/11/12, with diagnoses of Alzheimer's disease, anxiety, depressive disorder, dementia and persistent mental disorder. R22's admission Minimum Data Set (MDS) dated 09/18/12, indicated the resident required extensive assistance with bed mobility, dressing and toileting, supervision with personal hygiene and set up with eating. A significant change in status MDS dated 11/21/12, indicated R22 needed extensive assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. R22 was non-ambulatory, incontinent of bowel and bladder and required extensive to total assistance with their wheelchair for mobility needs. The Care Area Assessment (CAA) summary dated 11/26/12, indicated R22 had declined in status and required extensive to total assist with all activities of daily living and a recommendation was made for hospice services. Although R22 was dependent on staff for assistance with ADLs, the facility failed to develop an individualized ADL care plan that was based on a comprehensive assessment of the resident's ADL needs. There were no directions for the staff regarding R22's personal hygiene, grooming, toileting, transferring, bathing and bed mobility needs. On 02/01/13, at 2:00 p.m. the director of nursing verified these findings and stated she didn't know why there was no ADL care plan in R22's medical record.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 26 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and closed record review the facility failed to develop a temporary care plan that addressed the immediate care needs for 1 of 1 newly admitted resident (R 41) in the sample who received dialysis treatments. Findings include: R41 was admitted to the facility on 12/21/12, and expired 12/23/12. R41 had a diagnosis of end stage renal disease and received routine dialysis treatments. R41's careplan did not include interventions that directed staff to monitor for checking of the dialysis access site for bleeding. The medical record lacked evidence of a temporary care plan that addressed R41's immediate dialysis care needs. On 2/1/13, at 11:30 a.m. the director of nursing (DON) verified R41 received dialysis treatments and stated a temporary care plan had not been developed to address the resident's immediate dialysis care needs upon admission. The facility's Care Plans- Preliminary policy dated 4/6/12, indicated a plan of care to ensure the residents immediate care needs are met and maintained would be developed within 24 hours of admission. Furthermore, the facility policy for	F 281	F281 R41 Expired on 12/23/12. Policy regarding Care Plans – Preliminary and Hemodialysis Access Care will be reviewed and updated by Director of Nursing or designee. All nursing staff will be educated on policies by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to ensure all residents have either a temporary or comprehensive care plan in place to address their immediate care needs. 2. All new admissions will be audited weekly to ensure a temporary care plan is in place within 24 hours for their immediate care needs. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	3/13/13

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F 281	Continued From page 27 Hemodialysis Access Care dated 10/10, directed the staff to monitor access site care and monitoring for signs of infection, checking for the color, temperature and radial pulse, and to check for the patency at the site to feel the "thrill" as an intervention for residents with renal dialysis. The care of the site after dialysis directed staff that if the resident experienced heavy bleeding, pressure was to be applied and the emergency dialysis center was to be contacted. Staff was to verify the clamps or lumens were closed and the policy indicated heavy bleeding was a medical emergency and resident was not to be left alone.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in accordance with the written plan of care for 1 of 3 residents (R71) in the sample who was dependent on staff for nail hygiene and 1 of 3 residents (R57) who was at risk for falls. Findings include: R71 was totally dependent on staff for all of his personal hygiene needs and the facility failed to provide the necessary care and service to maintain nail hygiene.	F 282	F282 R71 Care plan reviewed and updated regarding nail care and behaviors. R57 Care plan reviewed and updated regarding fall interventions. Policy regarding Care of Fingernails/Toenails and Using the Care Plan will be reviewed and updated by Director of Nursing or designee. All staff will be educated on policies by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits:	3/13/13

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F 282	Continued From page 28 The resident's ADL care plan revised 1/27/13, identified the R71's ADL deficits and directed staff to clean and trim the resident's finger nails weekly with his bath and as needed. In addition, R71's nutrition care plan directed staff to encourage the resident to eat finger foods independently. The Group B nursing assistant assignment sheet updated 1/28/13, directed staff to clean the resident's nails out on bath days. On 1/29/13, at 12:03 p.m. the resident was observed in the main dining room with a black substance under his fingernails. On 1/31/13, at 4:10 p.m. the resident was observed sitting in the wheelchair in the day room. R71's finger nails were long and the black substance remained under the fingers nails of his left hand. On 1/31/13, at 4:15 p.m. the facility's administrator and assistant administrator confirmed the resident's finger nails were soiled and stated the nursing assistants should be cleaning R71's nails during his bath. The administrator stated the resident has a history of digging in his feces; however, this was not identified in the resident's care plan. R57's care plan, 11/30/12, directed staff that R57 was unable to communicate needs and required staff intervention. The care plan directed staff to have R57 demonstrate task or request if able. 1/14/13 care plan indicated resident has limited physical mobility related to Parkinson's. "I use a wheel chair for primary mobility, I am able to propel myself to my destination". 11/26/12 bed alarm and chair alarm initiated, check for proper	F 282	1. 5 Residents will be randomly audited per week to ensure resident fingernails are clean. 2. 5 Residents will be randomly audited per week to ensure fall interventions are in place per the care plan. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 282	Continued From page 29 function each shift, assess for pain and provide relief, have commonly used articles within easy reach, ensure environment is free of clutter, resident to wear proper and non slip footwear, reinforce need to call for assist, call bell attached when in bed. Resident to have dyson (anti slip pad) applied to wheel chair initiated on 1/17/13. On 1/30/13 during multiple observations, R 57 was observed in the wheel chair and did not have a chair alarm in place. At 7:00 a.m., 12:00 p.m., and 4:00 p.m., R57 was observed in his wheel chair, at the dining room table and in his room and did not have an alarm on the wheel chair. On 1/31/13 R57 was sitting at the dining room table at 8 a.m. with no alarm on and again at 3:30 p.m. with no alarm on. At 4:35 p.m. the resident was observed to be sitting on the edge of his bed and had no alarm on. At approximately 5:00 p.m.,The DON confirmed that R57 was to have an alarm on in wheel chair/ and in bed according to the care plan. The DON looked at the wheel chair and the bed and was unable to locate either alarm.	F 282		
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.	F 309	F309 R41 Expired on 12/23/12. Policy regarding Hemodialysis Access Care and Care Plans - Preliminary will be reviewed and updated by Director of Nursing or designee. All licensed staff will be educated on policies by Director of Nursing or designee.	3/13/13

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F 309	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and closed record review the facility failed to assure necessary care and treatment was provided for 1 of 2 residents (R41) in the sample who received dialysis treatments. Findings include: R41's medical record lacked evidence of interventions for dialysis care including access site care and monitoring. R41 was admitted to the facility on 12/21/12 from assisted living, and expired 12/23/12. R41 had a diagnosis of end stage renal disease and received routine dialysis treatments. The medical record lacked evidence of a temporary care plan that addressed R41's immediate dialysis care needs. The medical record lacked specific orders for dialysis treatment and care and the medication/treatment administration record (MAR/TAR) lacked any dialysis site care information. The facility policy, Hemodialysis Access Care, dated 10/10 included access site care and monitoring for signs of infection, checking for the color, temperature and radial pulse, and to check for the patency at the site to feel the "thrill." The care of the site after dialysis directed staff that if the resident experienced heavy bleeding, pressure was to be applied and the emergency dialysis center was to be contacted. Staff were to verify the clamps or lumens were closed and the policy indicated heavy bleeding was a medical	F 309	Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to ensure all Dialysis residents have a temporary or comprehensive care plan including their immediate dialysis care needs, and monitoring listed on TAR. 2. All new admissions on Dialysis will be audited to ensure a temporary care plan is in place to address immediate dialysis care needs and monitoring is in place on TAR. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 309	Continued From page 31 emergency and resident was not to be left alone. On 2/1/13, at 11:30 a.m. the director of nursing (DON) verified R41 received dialysis treatments and stated she could not find information in the medical record regarding any dialysis treatments received since admission. The DON called the dialysis unit and learned R41 had missed his scheduled dialysis appointment on 12/21/12, admission date to the facility. The DON was unable to attain any further information from dialysis due to confidentiality guidelines. The DON was not aware R41 had missed the appointment as this information was not presented upon admission from the assisted living facility and was unsure of the procedure to follow when a scheduled dialysis appointment was missed. The DON confirmed the medical record lacked information regarding R41's dialysis care needs and stated a temporary care plan had not been developed to address the resident's immediate dialysis care needs. The facility's Care Plans- Preliminary policy, dated 4/6/12, indicated a preliminary plan of care to ensure the residents immediate care needs are met and maintained would be developed within 24 hours of admission.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide nail care for 1 of 3 residents (R71) in the sample who was dependent on staff for assistance with personal hygiene. Findings include: R71 was totally dependent on staff for all of his personal hygiene needs and the facility failed to provide the necessary care and service to maintain nail hygiene. On 1/29/13, at 12:03 p.m. the resident was observed in the main dining room with a black substance under his fingernails. On 1/31/13, at 4:10 p.m. the resident was observed sitting in the wheelchair in the day room. R71's finger nails were long and the black substance remained under the fingers nails of his left hand. R71's quarterly Minimum Data Set (MDS) dated 1/16/13 indicated the resident had severely impaired cognition and was totally dependent on staff for all his personal hygiene needs. The resident's ADL care plan revised 1/27/13, identified the R71's ADL deficits and directed staff to clean and trim the resident's finger nails weekly with his bath and as needed. In addition, R71's nutrition care plan directed staff to encourage the resident to eat finger foods independently. The Group B nursing assistant assignment sheet updated 1/28/13, directed staff to clean the resident's nails out on bath days.	F 312	F312 R71 Nails were cleaned on 1/31/13. Policy regarding Care of Fingernails/Toenails will be reviewed and updated by Director of Nursing or designee. All staff will be educated on policy by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audit: 1. 5 Residents will be randomly audited per week to ensure resident fingernails are clean. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	3/13/13

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F 312	Continued From page 33 On 1/31/13, at 4:15 p.m. the facility's administrator and assistant administrator confirmed the resident's finger nails were soiled and stated the nursing assistants should be cleaning R71's nails during his bath. The administrator stated the resident has a history of digging in his feces; however, this was not identified in the resident's care plan.	F 312		
F 320 SS=D	483.25(f)(2) NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide care that was based on a comprehensive assessment for 1 of 1 resident (R71) in the sample who experienced an increase in physically aggressive behavior. Findings include: R71 was admitted to the facility on 10/5/12 with diagnoses of progressive frontal temporal dementia, depression, severe expressive aphasia and a history of stroke and traumatic brain injury. A hospital discharge summary dated 10/5/12, indicated the resident had a significant history of physically aggressive behavior and had been	F 320	F320 A new psychosocial assessment was completed on R71 and behavioral care plan updated. Psych consult completed on R71 on 2/24/13. Policy regarding Behavior Assessment and Monitoring will be reviewed and updated by Administrator or designee. All Staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits:	3/13/13

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F 320	Continued From page 34 hospitalized for nearly three months for the management of this behavior. The discharge summary indicated R71's previous living facility refused to allow him to return due to aggressive, violent and disruptive behaviors. The discharge summary indicated the resident became agitated especially when overstimulated, R71 is for the most part cooperative if one is patient with him, R71 had demonstrated significant improvement with medications and during the last month of his hospital stay R71's agitation had improved greatly with no aggressive behaviors. R71's admission Minimum Data Set (MDS) dated 10/19/12 indicated the resident had severely impaired cognition, no mood or behavior symptoms and required total assistance with all activities of daily living. The MDS indicated R71 received multiple psychotropic medications including an antipsychotic and an antidepressant daily. A MN Psychosocial Assessment (MNPA) dated 10/10/12, described the resident as alert, confused, calm, cooperative and accepting of treatments, withdrawn and the resident had no inappropriate behaviors. A Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/12/12, indicated R71 "has no behavior symptoms at this time." A Psychotropic Drug Use CAA dated 10/12/12, indicated R71's "behaviors are under control." The care plan initiated on 10/22/12, indicated R71 had a mood/behavior problem related to dementia and therefore may have a problem adjusting to his new environment. The care plan indicated R71 may become agitated during cares	F 320	1. All resident's 2 previous MDS's will be audited to determine if there has been an increase in behaviors. Residents who have shown an increase in behaviors over the previous quarter will have a new psychosocial assessment completed and care plan updated. 2. Whole house audit will be completed to ensure each behavioral care plan has targeted behaviors and individualized interventions. 3. All new admissions will be audited to ensure an appropriate behavioral care plan, with individualized interventions, is put into place if appropriate. 4. 5 Random residents will be audited weekly to ensure comprehensive charting has been completed on behavioral flow sheets. 5. All resident's behavioral flow sheets will be audited weekly to ensure individualized interventions are effective, and if not, brought to weekly Standards of Care Meeting to review with IDT and implement new individualized interventions.	

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F 320	Continued From page 35 and will hit, kick or grab at staff, R71 is resistive to cares, R71 is unable to consistently communicate his needs and has impaired decision making skills. The care plan directed staff to administer medications as ordered, provide meaningful activities, encourage participation in cares, explain cares prior to beginning them, re-approach when resistive, provide consistency in routine and care givers, ask simple yes/no questions, provide one task at a time and offer two simple choices to reduce the stress of decision making and increase R71's sense of autonomy. Review of R71's Behavior/Intervention Monthly Flow Record (BIMFR) dated 11/2012, indicated the resident was monitored for physically aggressive behaviors directed towards others. There were no episodes of physically aggressive behavior in the month of November. Review of R71's BIMFR dated 12/2012, indicated the resident had multiple episodes of physically aggressive behaviors directed towards others on five shifts during the month. The BIMFR identified the following potential interventions: redirect, 1:1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature and back rub. There were no resident specific interventions listed on the form. On two of the shifts during the month the interventions used to alter R71's behavior were documented. The first entry indicated all of the above interventions were used to alter R71's behavior and the second time the intervention listed was 1:1. In both instances the resident's behavior symptoms remained unchanged by the interventions used. No interventions or outcomes	F 320	All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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	245097	A. BUILDING _____ B. WING _____	02/01/2013

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F 320	Continued From page 36 were identified for the remaining three shifts. Review of R71's BIMFR dated 1/2013, indicated the resident had multiple episodes of physically aggressive behaviors directed towards others on ten shifts during the month. The BIMFR identified the following potential interventions: redirect, 1:1, refer to nurses notes, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature and back rub. There were no resident specific interventions listed on the form. The interventions used to alter the resident's behavior were documented on four of the ten shifts. The interventions used included: redirect, 1:1, return to room and change position. The BIMFR indicated there was no change in the resident's behavior with the use of these interventions. No interventions or outcomes were identified for the remaining six shifts. A Weekly Behavior Monitoring Summary (WBMS) dated 12/15/12, indicated R71 had 11 episodes of physically aggressive behavior in the past week. The interventions used were "redirection" and the resident's response to the interventions was "no change." A MNPA dated 12/31/12, described the resident as alert, agitated, calm, withdrawn and physically abusive. Although the physically abusive behavior was newly identified, the documentation indicated the assessment was "Reviewed. No changes. For full psychosocial see 10/10/12." The nature and potential causes of the physical aggression was not identified. On 1/31/13, at 12:37 p.m. the facility's SW verified these findings and stated she was responsible for completing the MNPA.	F 320		

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F 320	Continued From page 37 The SW stated "I missed it." A WBMS dated 1/2/13, indicated R71 had six episodes of physical aggression in the past week. The interventions used were "redirection" and the resident's response to the interventions was "no change." A WBMS dated 1/15/13, indicated R71 had ten episodes of physical aggression in the past week. The interventions used were "redirection" and the resident's response to the interventions was "no change." R71's quarterly MDS dated 1/16/13, indicated the resident had physically aggressive behavior symptoms directed towards others on 4-6 days and resistive to cares on 1-3 days during the assessment reference period. The medical record lacked evidence of an assessment of these changes. A MNPA dated 1/31/13, described the resident as alert, agitated, calm, withdrawn and physically abusive. The MNPA indicated the residents ability to consistently communicate his needs was impaired, R71 had difficulty speaking and can become physically aggressive during cares and meals. R71 may strike out and kick the table. Although staff had identified an increase in physically aggressive behaviors since admission, the medical record lacked an assessment of these changes to determine their causative factors and appropriate interventions to decrease or eliminate the aggressive behavior. On 1/31/13, at 11:54 a.m. a nursing assistant	F 320		

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F 320	Continued From page 38 (NA)-A who familiar with R71's care stated sometimes the resident will hit if he gets agitated, if his incontinent product is wet or if he has to have a bowel movement. NA-A added, if R71 doesn't like his meal he will hit and he will stop hitting if we give him a grilled cheese sandwich, peaches and ice cream. NA-A stated R71 strikes out when he wants something. She added, we go through a list and as soon as we figure out what it is he wants his behavior improves. NA-A stated she has worked with R71 since he was admitted, she works both the day and afternoon shifts and the resident displays these types of behaviors about three times a week but, not daily. NA-A stated the resident's behaviors are worse in the afternoon and they have not really changed since he was admitted. On 1/31/13, at 12:11 p.m. the facility's social worker (SW) verified these findings and stated she was responsible to review the behavior flow sheets and complete the behavior items on the MDS. The SW stated R71's behavior changes would be discussed at the facility's Standards of Care meeting; the SW stated she does not attend the Standards of Care meetings. The SW stated she does not talk with nursing assistants when assessing the resident's behaviors and developing the care plan. The SW stated any changes to R71's care plan would be made by the director of nursing (DON) and the facility's administrator. The SW stated she did not complete an assessment of the resident's behavior changes. On 1/31/13, at 12:37 p.m. the facility's administrator, the assistant administrator, the SW and DON were interviewed regarding R71's	F 320		

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F 320	Continued From page 39 increase in physically aggressive behaviors. The administrator stated the team did discuss the resident's behavior changes at the Standards of Care meeting on 12/4/12, and decided a psych consult would be sought. R71's medical record lacked evidence of a psych consultation and the DON was asked to provide the documentation from the visit. The administrator and SW verified the resident had an increase in aggressive behavior. They were asked to provide an assessment of this increase and identify the interventions implemented for the resident's decline in behavior. No further information was provided.	F 320		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently implement interventions and provide adequate supervision for 1 of 3 residents (R57) in the sample who was experiencing repeated falls. Findings include: R57 had eight falls between 11/21/12 and 1/29/13 and the facility failed to consistently implement	F 323	F323 R57 Care plan and Group Assignment sheet will be reviewed and updated for current fall interventions. Policy regarding Assessing Falls and Their Causes will be reviewed and updated by Director of Nursing or designee. All Nursing staff will be educated on policy by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits:	3/13/13

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F 323	Continued From page 40 interventions to decrease the risk of falls. Furthermore, incident reports (IR) lacked the pertinent information necessary to complete a comprehensive analysis of each fall to enable the facility to determine appropriate and effective interventions to decrease R57's risk for falls. R57 was admitted with diagnosis of Parkinson's disease, pneumonia, chronic obstructive pulmonary disease, urinary incontinence, constipation, depression, impaired balance and dementia. The admission Minimum Data Set (MDS) dated 12/4/12, indicated R57 had moderately impaired cognition, required limited assistance with activities of daily living, had impaired balance, was frequently incontinent of bowel and bladder, was not on a toileting plan and had a recent history of falls. R57's care plan, revised on 1/17/13, indicated R57 was unable to communicate his needs to staff. The care plan identified R57's risk for falls and directed staff to apply a bed and chair alarm and to check the alarms every shift to ensure they were functioning properly (initiated on 11/26/12), Dicem used when in the wheelchair (initiated on 1/17/13), have commonly used articles within easy reach, ensure the environment is free of clutter, R57 will wear proper and non-slip footwear, reinforce the need to call for assist and the call light attached when in bed. The nursing assistant (NA) Group C assignment sheet revealed R57's ADL (activities of daily living) care information was missing. R57 had recently moved from Group B to Group C and the assignment sheet had not been updated with the resident's care needs. The Group B NA	F 323	1. All fall incident reports from the previous quarter will be audited to ensure interventions are care planned appropriately. 2. 5 Residents will be randomly audited per week to ensure fall interventions are in place. 3. 5 Fall incident reports will be randomly audited per week to ensure they are completed thoroughly. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 323	Continued From page 41 assignment sheet indicated R57 required assist of one for all transfers and bed mobility, R57 was incontinent of bowel and bladder and was on an every two hour and as needed check and change program, R57 required a personal alarm when in bed and chair as well as Dicem on the wheelchair. The assignment sheet also alerted staff to R57's frequent attempts to self-transfer and directed staff to check R57's personal alarms to determine if they were functioning properly when assisting with transfers. R57 had multiple falls and the IRs lacked the details needed to identify patterns, ineffective interventions and determine appropriate interventions to minimize the risk of future falls. An IR dated 11/21/12, indicated R57 had a witnessed fall with no injuries. The IR indicated the fall occurred when R57 sat in a chair that lacked arm rests. The IR was incomplete and had numerous blank areas. R57 was educated to sit in dining chairs with arm rests for more support. An IR dated 11/22/12, indicated R57 had an unwitnessed fall with no injuries in his room. R57 was found sitting on the floor by his wheelchair and stated "I missed my chair." The IR was incomplete and had numerous blank areas. R57 was reminded to lock the wheelchair brakes before sitting in the wheelchair. An IR dated 11/25/12, indicated R57 had an unwitnessed fall with no injuries in his room. The IR indicated R57's personal alarm was sounding; when staff arrived they found the resident kneeling on the floor near his bathroom. R57 was toileted and assisted back into bed. The IR was	F 323		

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F 323	Continued From page 42 incomplete. A progress note (PN) dated 11/26/12, indicated physical therapy is working with resident on gait/balance and R57 currently had alarms in place, was encouraged to use call light and had verbalized understanding of this. An IR dated 11/29/12, indicated R57 had a fall while ambulating with a walker in the hallway. No injuries were noted. A PN dated 11/30/12, indicated the facility will obtain order for physical therapy to evaluate and treat due to history of falls. An IR dated 12/6/12, indicated R57 had an unwitnessed fall with no injuries in his room. R57 had been incontinent of bowel and was attempting to change his incontinent product at the time of the fall. A throw rug was noted on the floor near the bedside at the time of the incident. The IR was incomplete. R57 was asked to leave his shoes on when up and wait for staff assistance with incontinence cares. Staff was educated regarding R57's preferences for bedtime cares right after supper and his desire to go to bed early. The throw rug was removed from the bedside. A PN dated 12/10/12, indicated R57 was placed on an every two hour toileting schedule to decrease his falls risk. An IR dated 12/15/12, indicated R57 had an unwitnessed fall with no injuries outside. The resident was found sitting on the sidewalk and stated "I fell out of my chair." R57's wheelchair was assessed and Dicem was applied to decrease the potential for sliding out of the wheelchair. An IR dated 12/29/12, indicated R57 had a fall in	F 323		

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F 323	Continued From page 43 his room with no injuries. R57 was found sitting on the floor next to his wheelchair. R57 had been incontinent and was attempting to change his incontinent product when the incident occurred. Staff was provided education regarding the appropriate use of Dicem on the wheelchair to prevent sliding and R57's behavior care plan was reviewed. An IR dated 1/29/13, indicated R57 had a fall with no injuries in the therapy room. R57 had lost his balance and fell. The IR was incomplete. Staff was educated on the importance of staying close to R57 while standing. The care plan indicated R57 had a personal alarm on the bed and chair however, on multiple days during the survey R57 was observed without the alarms in place. On 1/30/13, at 7:00 a.m. R57 was observed sitting in his wheel chair at the dining table. There was no personal alarm on R57's wheelchair. On 1/30/13, at 12:00 p.m. was observed sitting in his wheelchair with no personal alarm in place. On 1/30/13, at 4:00 p.m. R57 was observed sitting in his wheelchair in his room with no personal alarm in place. There was a note taped to the wall in R57's room to remind him to use the call light for assistance. On 1/31/13, at 8:00 a.m. R57 was observed sitting in his wheelchair at dining table with no personal alarm in place. On 1/31/13, at 3:30 p.m. R57 was observed eating ice cream while sitting in the wheelchair in his room. During the observation R57 attempted to self-transfer; he did not have his shoes on and his feet were sliding	F 323		

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F 323	Continued From page 44 out from underneath him. Per surveyor intervention R57 was asked to sit down. R57 stated he wanted to go back to bed. R57's call light was on the bed and R57 was asked to turn on the call light for assistance. There were no personal alarms on R57's bed or wheelchair at the time. On 1/31/13, at 4:35 p.m. R57 was observed sitting on the edge of his bed. During the observation R57 removed his shirt and then attempted to stand and remove his pants. R57's incontinent product was wet with urine. Per surveyor intervention R57 was asked to sit down and turn on his call light for assistance, which he did. A nursing assistant (NA)-A responded to the resident's call light and stated R57 transfers himself, sometimes staff help him with transfers and the resident does not use a chair or bed alarm. On 2/1/13, at 8:00 a.m. R57 was observed sitting in his wheelchair in the dining table with no personal alarm in place. On 1/31/13 at approximately 5:00 p.m., the director of nursing (DON) confirmed R57 should have a personal alarm on both his wheelchair and bed according to R57's care plan. The DON informed NA-A the resident should have an alarm on his wheelchair and bed. NA-A stated they had not been using the alarms because R57 does not like them. NA-A stated R57 would remove the alarm and throw it. The DON asked R57 where the alarms were and R57 replied, under the bed. The DON found one of the alarms under R57's bed and the other on top of the refrigerator in the resident's room. When asked, R57 declined to	F 323		

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F 323	Continued From page 45 have the personal alarms put back on the wheelchair and bed. On 1/31/13, at 3:15 p.m. the physical therapy assistant (PTA) stated R57 is weak in the lower extremities and has trouble picking up his feet, R57 needs a lot of verbal cues and balance testing has been tried but, unsuccessful. The occupational therapy assistant (OTA) stated R57 is impulsive and has poor safety awareness. The OTA stated cognitive testing completed 12/5/12 indicated R57 had severe cognitive impairment. The facility's policy addressing falls directed staff to assess all falls to determine the possible or likely causes. The policy directed staff to evaluate the chains of events or circumstances preceding the fall and consult with attending physician or medical director to confirm the cause(s). The attending physician will examine the resident or may initiate testing to try to identify causes. If the cause of the fall cannot be determined and no additional evaluation is completed by the physician or nursing, staff will document the rationale in the medical record.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 New consents for psychotropic medications will be completed for R79. Parameters for PRN medications will be put in place for R79.	3/13/13

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F 329	Continued From page 46 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 facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 1 of 10 residents (R79) reviewed for medication use. Findings include: R79 received multiple psychotropic medications and lacked indications for use and monitoring of the medications effectiveness. Furthermore, R79 received multiple PRN (as needed) psychotropic medications and the medical record lacked parameters for the use of these medications. In addition, the forms used by the facility to obtain consent for the use of the medications failed to identify the diagnosis, target behaviors and treatment goals for the use of the medications.	F 329	Policies regarding Antipsychotic Medication Use and PRN Orders will be reviewed and updated by Director of Nursing or designee. All Licensed Nursing staff and TMA's will be educated on policies by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. New consents will be completed on all residents currently receiving psychotropic medications. 2. 2 New admissions each week will be randomly audited to ensure psychotropic consents are completed thoroughly. 3. Whole house audit will be completed to ensure all residents currently receiving PRN psychotropic medications have parameters in place. 4. 2 New admissions per week will be randomly audited to ensure any PRN psychotropic medications have parameters in place.	

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F 329	Continued From page 47 R79 was admitted to the memory care unit 1/15/13, with a diagnosis of dementia. The history and physical (H & P) dated 1/16/13, indicated the resident had dementia, with behavioral disturbances. The H & P further revealed while in the hospital the resident had significant aggressive behaviors (after surgery) but in spite of that he appeared to be pleasant with significant grandiosity. R79 was admitted with the following medications: Seroquel 75 milligrams (mg) three times a day (TID) for agitation, Buspar 5 mg TID for anxiety, Trazodone 50 mg PRN for insomnia, Haldol 5 mg every four hours PRN for agitation. There were no parameters identified for the use of the PRN psychotropic medications. The informed consent for Seroquel (an antipsychotic medication) dated 1/20/13, indicated the medication was an antidepressant. The consent form failed to identify the diagnoses for which the drug was being given, the target behaviors and the goals of treatment. The informed consent for the Trazodone dated 1/20/13, indicated the medication was administered for sleep hygiene. The consent form failed to identify the diagnoses for which the drug was being given and treatment goals. The informed consent for Haldol dated 1/20/13, listed potential contributing factors as, stressors due to change in usual routine or caregiver. The consent form failed to identify non medication related approaches, the diagnoses for which the drug was being given and target behaviors.	F 329	All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	

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F 329	Continued From page 48 The informed consent for the Buspar dated 1/20/13, failed to identify non medication related approaches, the diagnoses for which the drug was being given, target behaviors and the goals of treatment. Review of the January 2013 Medication Administration record indicated R79 routinely received Seroquel 75 mg and Buspar 5 mg routinely at 8 a.m., 2 p.m. and 8 p.m. daily. In addition R79 had physician orders for Trazadone 50mg PRN and Haldol 5mg PRN. A nurses noted (NN) dated 1/15/13, indicated the resident was agitated on the evening shift and wanted to call different people to get his affairs in order. PRN Haldol and Trazodone were administered and effective. Another NN dated 1/16/13, indicated R79 had been agitated at times over his financial affairs and was given PRN Haldol and Trazodone to help him "relax." On 1/20/13, 1/22/13, 1/23/13,1/25/13, 1/29/13 and 1/30/13, PRN Haldol and Trazodone were administered for agitation/restlessness. The medical record did not describe the resident's behavior in any detail or identify the nonpharmacological interventions used in an effort to eliminate R79's behavior prior to administering the medications. The comments section on the MAR indicated effective. A psychological assessment was completed by nursing on 1/21/13, and R79 was identified as being alert, anxious, cooperative with staff, and friendly. R79 had concerns regarding his wife, going home and his money. The Care Area Assessment (CAA) completed 1/22/13, did not identify any issues with mood or behavior. A mood interview was completed and	F 329		

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

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	245097	A. BUILDING _____ B. WING _____	02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 49 no aggressive behaviors were noted. It did indicate R79 became anxious when thinking of his wife, who is in another nursing home, his money and his home. The brief interview for mental status (BIMS) was completed revealed the resident scored 11 (on a scale of 1-15) indicating moderate cognitive impairment. R79's care plan dated 1/21/13, indicated the resident had no physical or verbal aggression. The care plan indicated R79 does make repetitive statements and can become anxious. The care plan listed the following interventions: encouragement, support, assistance, develop activities, administer medications and monitor the effectiveness. The facility's Antipsychotic Medication Use policy, revised on 1/31/13, indicated antipsychotic medications shall be used only when it is necessary to treat a specific condition. Staff was directed to document in detail the resident's target symptoms. The policy indicated if antipsychotic medications are used as PRN repeatedly, over several days, the physician needed to be contacted to evaluate the resident and whether the continued use was appropriate. The facility's PRN Orders policy dated 11/22/11, indicated non pharmacological interventions would be used in conjunction with medication therapy. The pharmacy consultant was contacted 2/1/13, at 3:08 p.m. regarding the use of Haldol along with Trazodone. The pharmacy consultant stated there needed to be appropriate diagnoses and justification for use of the medications, non	F 329		

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F 329	Continued From page 50 pharmacological interventions should be utilized and the use of the two medications together along with Seroquel and Buspar could increase the resident's sedation. On 2/1/13, at 4:35 p.m. the director of nursing (DON) confirmed there was no clear indication, diagnoses or parameters identified for the use of the Haldol and Trazodone. The DON verified there were no non-pharmacological interventions identified to manage the resident's behavior symptoms and stated staff should not give the medications together as it could increase problems for the resident.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 51 (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 a multi-resident use glucometer (a device that measures blood glucose levels) had been sanitized after each use for 1 of 1 resident (R10) in the sample who had a blood glucose test completed. This action had the potential to affect six of the residents who had diabetes and resided on the 200 wing. Findings include: On 1/28/13, at 5:50 p.m. the licensed practical nurse (LPN)-C performed a blood glucose test on R10 using the facility's universal glucometer. After the test the LPN-C placed the glucometer in the medication cart without sanitizing it. At 6:10 p.m. the glucometer had not yet been cleaned and after being asked LPN-C took out an alcohol wipe to clean the glucometer. When asked, LPN-C stated this is what we use to clean the	F 441	F441 Policy regarding Obtaining a Fingerstick Glucose Level will be reviewed and updated by Director of Nursing or designee. All Licensed nursing staff and TMA's will be educated on policy by Director of Nursing or designee. All licensed nursing staff and TMA's will demonstrate competency in sanitizing the glucometer. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. 5 Audits will be randomly completed per week to ensure staff are properly sanitizing the glucometer. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	3/13/13

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F 441	Continued From page 52 glucometer. On 1/30/13 at 8:10 a.m. the director of nursing stated the glucometer should be sanitized after each use with a Cavi Wipe and the nurse should be aware of that. The facility's Obtaining a Fingerstick Glucose Level policy dated 1/30/13, policy indicated the glucometer is to be disinfected between each use according to the infection control standards of practice.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a functioning nurse call system in the bathrooms for 4 of 4 residents (R8, R26, R47, R51) who utilized the call system. Findings include: Two bathrooms on the memory care unit utilized by R8, R26, R47, R51 did not have a functioning call systems in the bathroom. R8, R26, R47, and R51 who resided on the secure unit were in rooms that utilized shared bathrooms. In one shared bathroom there was no pull cord on the call system and in another	F 463	F463 Call light cords were replaced in the resident bathrooms affecting R8, R26, R47 and R51. Policy regarding Answering the Call Light will be reviewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Maintenance Director or designee completing the following audits: 1. Whole house audit will be completed to ensure all resident care areas have a functioning call light. 2. 5 Random call lights will be audited per week to ensure call lights are functioning properly.	3/13/13

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F 463	Continued From page 53 bathroom the cord on the call system in the bathroom was approximately three inches long. During the environmental tour on 1/31/13, at 10:00 a.m. the facility's maintenance man verified these findings and stated he completes a monthly check of the resident rooms and bathrooms and nursing staff should be contacting him when the call system needs to be repaired. He was unsure how long the bathroom call systems had been like this.	F 463	All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: March 13, 2013	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a system to ensure that narcotics were dispensed and documented in accordance with professional standards for 4 of 14 residents (R19, R21, R50, R73) in the sample who received narcotics.	F 514		

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F 514	Continued From page 54 Findings include: R21's medication administration records did not identify all the medications the resident had received. In addition, the resident received a Fentanyl 75 mcg (micrograms) transdermal patch (a narcotic pain medication) on two consecutive days when it was ordered to be administered every three days and the medication administration record lacked a rationale. During an observation of medication pass on 1/31/13, at 4:30 p.m. with the trained medication aide (TMA)-A it was noted that R21 had received a Fentanyl 75 mcg transdermal patch on 1/9/13 and again on 1/10/13. Review of the physicians orders revealed R21 should receive a Fentanyl 75 mcg transdermal patch every 72 hours. The medication administration records (MAR) dated Jan 2013, lacked a rationale for administering the second patch on 1/10/13. When interviewed on 2/1/13 at approximately 1:45 p.m. (RN)- C indicated the patch had come off and he replaced it however he did not chart it. He knew he should have signed it off and that was an error. Further review revealed the facility's bound narcotic register indicated Lyrica 125 mg (milligrams) was removed from R21's medication supply of controlled drugs on 1/1/13 and again on 1/2/13; however, the resident's January 2013 MAR failed to indicate the medication was administered to R21. The facility's bound narcotic register indicated Lorazepam 0.5 mg was removed from R21's medication supply of controlled drugs on 1/5/13, 1/9/13 and 1/16/13; however the resident's	F 514	F514 Whole house audit was completed to ensure proper reconciliation of all narcotic medications. This included reconciliation of narcotic medications for R19, R21, R50, R73. Policy regarding Administering Medications will be reviewed and updated by Director of Nursing or designee. All licensed nursing staff and TMA's will be educated on policy by Director of Nursing or designee. All licensed nursing staff and TMA's will demonstrate competency on medication documentation. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. 10 Controlled substances on random residents will be audited per week to ensure proper documentation. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: March 13, 2013	3/13/13

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F 514	Continued From page 55 January 2013 MAR failed to indicate the medication was administered to R21. The facility's bound narcotic register indicated Oxycodone 10 mg was removed from R21's medication supply of controlled drugs on 1/3/13, 1/5/13, 1/11/13, 1/25/13, twice on 1/26/13, and again on 1/27/13; however, the resident's January 2013 MAR failed to indicate the medication was administered to R21. R50's medication administration records did not identify all the medications the resident had received. R50's physician's orders indicated the resident could receive Vicoden 5/500 mg 1-2 tablets every 4-6 hours as needed and oxycontin 10 mg every 12 hours as needed. Review of the facility's bound narcotic register indicated one tablet of Vicodin 5/500 mg was removed from R50's medication supply of controlled drugs on 1/10/13, 1/11/13, 1/13/13, 1/14/13, and 1/15/13; however, R50's January 2013 MAR failed to indicate the medication was administered to R50. The facility's bound narcotic register indicated one tablet of oxycontin 10 mg was removed from R50's medication supply of controlled drugs on 1/20/13, 1/26/13, and 1/30/13; however, R50's January 2013 MAR failed to indicate the medication was administered to R50.	F 514		

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F 514	Continued From page 56 R19's medication administration records did not identify all the medications the resident had received. R19's physician's orders indicated the resident could receive Ambien 10mg and Valium 5 mg three times a day. Review of the facility's bound narcotic register indicated one tablet of Ambien 10 mg was removed from R19's medication supply of controlled drugs on 1/9/13; however, the resident's January 2013 MAR failed to indicate the medication was administered to R19. The facility's bound narcotic register indicated one tablet of Valium 5 mg was removed from R19's medication supply of controlled drugs on 1/1/13 and 1/3/13; however, the resident's January 2013 MAR failed to indicate the medication was administered to R19. R73's medication administration records did not identify all the medications the resident had received. R73's physician's orders indicated the resident could receive Vicodin 5/325 mg 1-2 tablets every four hours as needed Review of the facility's bound narcotic register indicated Vicodin 5/325 mg was removed from R73's medication supply of controlled drugs on 1/2/13 (2 tablets), 1/5/13 (4 tablets sent to dialysis), 1/6/13 (2 tablets), 1/8/13 (4 tablets sent	F 514		

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F 514	Continued From page 57 to dialysis), twice on 1/9/13 (2 tablets each time), three times on 1/10/13 (4 tablets to dialysis and 2 tablets the other two times), twice on 1/11/13 (2 tablets each time), 1/12/13 (4 tablets to dialysis), 1/16/13 (4 tablets sent with resident), 1/17/13 (4 tablets sent to dialysis), 1/20/13 (2 tablets), 1/24/13 (2 tablets), 1/25/13 (dose signed as 1 on narcotic record however count indicated 2 had been removed), 1/26/13 (4 tablets sent to dialysis), 1/28/13 (2 tablets), and 1/29/13 (4 tablets sent to dialysis). The resident's January 2013 MAR failed to indicate the medication was administered to R73. On 2/1/13, at 8:45 a.m. the facility's administrator, assistant administrator, director of nursing and a registered nurse (RN)-B were interviewed regarding the controlled substance discrepancies. The facility's administrator verified these findings and stated after reviewing the documentation and interviewing the staff involved the facility determined staff had made several documentation errors, the staff need to be educated on the importance of documentation, more oversight of narcotic administration and documentation needed. The administrator indicated R19, R21, R50, and R73 were also interviewed at various times on 1/31/13 and 2/1/13 as to whether or not they could recall receiving pain medications as ordered or requested. R19, R50 and R73 all alert and oriented could not recall any issues with pain administration. R21, who had some cognition issues related to dates and times, as identifed on the quarterly minimum data set (MDS), stated, "no they have it jumbled up somehow, has gotten	F 514		

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F 514	Continued From page 58 lost before."	F 514		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF A ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Fire Marshal Division. At the time of this survey, Faribault Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POCok KB 3-8-13 RECEIVED MAR - 5 2013 DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL	

DC: 03.13.2013

EXIT: 02.01.2013

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

Administrator 3/1/13

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

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Faribault Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1992, addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 44 beds at the time of the survey.	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029 SS=D	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 44 residents. Findings include: On facility tour between 10:00 AM and 12:30 PM on 01/29/2013, observation revealed that the following were found: 1. Basement - Laundry room (over 100 square feet), door does not latch 2. Basement - storage room # B-13 over (50 square feet), does not have an automatic door closer 3. Basement - storage room # B-11 over (50 square feet), does not have an automatic door	K 029	K029 1. Basement – Laundry room door fixed so it latches. 2. Basement – Storage room #B-13 added a door closure. 3. Basement – Storage room #B-11 added a door closure. 4. Basement – Storage room #B-7 added a door closure. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: January 30, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245097	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/29/2013

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K 029	Continued From page 3 closer 4. Basement - storage room # B-7 over (50 square feet), does not have an automatic door closer These deficient practices were confirmed by the Administrator (BS) at the time of discovery.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7 and 1999 NFPA 13, 5-13.6 FINDINGS INCLUDE: On facility tour between 10:00 AM and 12:30 PM on 01/29/2013, observation revealed that the	K 056	K056 1. Basement – Storage room #B-7 – sprinkler installed in closet and ceiling tiles placed. 2. Basement – Central supply storage room – sprinkler installed in closet and ceiling tiles placed. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: February 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245097	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/29/2013

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K 056	Continued From page 4 following was found: 1. Basement - Storage room # B-7, inside this room the walk-in closet does not have fire sprinkler protection and walls do not go to deck for proper activation 2. Basement - Central supply storage room, inside this room the walk-in closet does not have fire sprinkler protection and walls do not go to deck for proper activation These deficient practices were confirmed by the Administrator (BS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 056		