Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2019

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Number Project Numbers H5499011C, 5499012C, H5499013C, H5499014C, H5499016C

Dear Administrator:

On March 18, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 17, 2019.

Based on the findings of this visit, we recommended to the CMS Region V Office the following remedy:

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

On March 28, 2019, we informed about the following enforcement remedies:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 17, 2019 would remain in effect. (42 CFR 488.417 (b))

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

Also, we notified you in our letter of March 18, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 17, 2019.

On April 19, 2019, the Minnesota Department of Health completed a Post Certification revisit (PCR) and on and April 25, 2019 the department 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 the surveys completed on February 26, 2019 and March 14, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2019. We have determined that your facility has corrected the deficiencies issued at the time of the surveys on February 26, 2019 and March 14, 2019, as of April 6, 2019.

An equal opportunity employer.

As a result of the revisit findings this Department recommended to the CMS Region V Office the following actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 17, 2019 be rescinded effective April 6, 2019. (42 CFR 488.417 (b))

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Electronically delivered

May 2, 2019

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

Re: Reinspection Results - Project Numbers H5499011C, H5499012C, H5499013C, H5499014C

Dear Administrator:

On April 19, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 26, 2019, with orders received by you on March 18, 2019. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered

March 18, 2019

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Numbers H5499011C, H5499012C, H5499013C, H5499014C

Dear Administrator:

On February 26, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) , as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 17, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 17, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 17, 2019.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 17, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Caledonia Rehabilitation & Retirement Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 17, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

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:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731 Fax: (507) 206-2711

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING ______ B. WING ______	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA REHABILITATION & RETIREMENT CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

(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 On February 10, and 26 2019 an abbreviated survey was completed at your facility to conduct a complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5499012C. Deficiency issued at F Tag #F609, F689 H5499013C. Deficiency issued at F Tag #F609, F689 H5499014C. Deficiency issued at F Tag #F600, F609, F610, F744 H5499011C. Deficiency issued at F Tag #F600, F609, F684, F689, F744, F755 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		3/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 03/27/2019

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 600	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from abuse following two separate resident to resident altercations initiated by R4 for 2 of 5 residents (R6, R7) reviewed for resident altercations. Findings include: R4's undated Face Sheet, indicated R4 was admitted to the facility on 12/18/19, with diagnosis of dementia without behavioral disturbance. On 12/27/18, dementia with behavioral disturbance was added to the Face Sheet. R4's Minimum Data Set (MDS) assessment dated 1/15/19, continued to reflect the same levels of cognition, signs and symptoms of delirium, and absence of hallucinations/delusions as the aforementioned assessments. The MDS indicated a change in behavioral symptoms that included: R4 had physical and verbal behaviors that were directed at others one to three days during the assessment period, increase in wandering behaviors from one to three days to	F 600	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R4 was discharged from the center to prevent any further altercations How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents progress notes reviewed over last 30 days to ensure no other altercations between residents were noted What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education with all staff regarding steps to take during an unsafe situation, always	

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F 600	Continued From page 2 four to six days during the assessment period. The MDS also indicated R4 had rejection of care behaviors one to three days. The MDS also indicated R4 was administered an antipsychotic medication for 6 days, and antianxiety medication on 4 days. The MDS indicated the level of care for activities of daily living had increased: For Bed mobility, transfers, walk in room and corridor, locomotion on and off the unit, dressing and toilet use required extensive assistance from two or more staff members. R4's Behavior care plan initiated on 1/11/19, indicated R4 had behavioral problem related to wondering, physically abusive, disruptive, and dementia, with goal of behaviors will not cause harm to self or others. The care plan interventions dated 1/11/19, included -Assess pattern, intensity, and duration of the problem behavior. Attempt to determine if behavior is associated with particular events. Assess for recent medication changes, change in environment as possible causes. -Provide calm reassurance, redirection, or distractions and assess effectiveness. Provide positive reinforcement for appropriate behaviors. Confront gently and respectfully when behavior is inappropriate and set limits. Share effective interventions with other staff members. -Maintain a routine and stress free environment as possible, keep noise to a minimum. Encourage activities and socialization. -Include and/or responsible party in treatment plan. Notify physician and update as indicated by change in condition treatment. R4's psychotropic care plan initiated on 1/7/19, indicated R4 required Seroquel related to behavioral management-dementia, corresponding interventions at the time care plan	F 600	remove residents away from danger prior to trying to deescalate the situation. DON to review all pre-admission paperwork of all referrals to ensure that the center is able to meet the needs of the resident and any behaviors are able to be handled at the center. Education included care plan updates to include behaviors with appropriate interventions. DON to audit charts M-F during the clinical review process including the 24-hour report, alert report and new behaviors. All behaviors will be brought to the daily clinical meeting M-F where IDT will review and implement any new interventions needed. How the facility plans to monitor its performance to make sure that solutions are sustained. RCD will audit progress notes, alert charting and IDT notes weekly for 5 weeks to ensure any new behaviors or negative situations were reviewed and appropriate interventions were implemented. Annual training with quiz for all staff regarding abuse and how to protect residents.	

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F 600	Continued From page 3 was initiated included monitoring for side effects and effectiveness every shift. The care plan was not revised to include target behaviors until 1/17/19. The intervention directed staff to monitor/record occurrence for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/others, ect). and document per facility protocol. R7's quarterly MDS dated 1/10/19, indicated R7 did not have cognitive impairment. The MDS also indicated R7 required extensive assistance from one staff member for transfers and ambulated with supervision. Review of R7's record included a progress note dated 1/10/19, at 7:30 a.m. included, "resident reported other resident wandered into her room she told him to leave and he tried to taker her slippers. resident stated loudly "those are my slippers" and took them from him. She reports he hit her open palm on the left side of her head. She states it did not hurt, just startled her". A follow up progress note dated 1/10/19, at 8:35 a.m. indicated no injuries as a result of the incident. R7's progress note dated 1/9/19, at 8:17 p.m. included, R7 was hit by R4 in the resident's room. R7 said it didn't hurt her and the two residents were separated by staff and made the nurse aware. Writer made the resident power of attorney and director of nursing aware of the situation. Incident did not result in injury to either resident. R4 was put to bed and he would be continued to be monitored.	F 600		

F 600 Continued From page 4 F 600

R6's significant change Minimum Data Set (MDS) 11/21/18, indicated R6 had moderate cognitive impairment. The MDS also indicated R6 required supervision with set-up help for transfers and locomotion on and off the unit, and did not ambulate.

Review of a Vulnerable Adult (VA) report dated 1/31/19, indicated an incident of resident-to resident physical abuse occurred. The incident occurred at 12:00 a.m., but was not reported to the state agency until 11:06 a.m. The incident report indicated R4 pushed R6 in a wheelchair into a mechanical lift in the hallway and was hitting R6 on top of the head with his fist. The investigative summary dated 2/7/19, identified R4 behavior seemed to escalate when being redirected. R6 who was hit had no bruising and stated she was scared of him. The provider has reviewed R4's medications and altered for improvement of mood/behavior and was in the process of moving to a facility with a memory care unit. The summary indicated the actions to prevent reoccurrence to other residents included distractive activities every evening for R4 has been helpful to reduce behavior; such as pushing cars instead of pushing other residents in wheelchairs.

Review of R4's and R6's record lacked evidence of documentation related to the 1/31/19 incident.

During an interview on 2/10/19, at 8:45 a.m. R6 stated R4 was not a very nice man. R6 stated R4 was going to tear down my curtains so she hollered at him and instead tore off her bed quilt. R6 indicated R4 left her room after she kept hollering at him. R6 stated she thought she told

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CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

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F 600	Continued From page 5 staff, someone in a black dress, but could not say for sure if the person in a black dress was a staff member. R6 indicated she kind of remembered him pushing her in the wheelchair and hitting her head on the mechanical lift, staff intervened. R6 stated R4 wondered around the facility and yelled at other residents when he got mad, but has not heard him do that lately. During an observation on 2/10/19, at 10:44 a.m. R4 sat in a recliner chair in his room. Nursing assistant (NA)-A placed a gait belt around R4's waist and placed a walker in front of him. NA-A continuously and repeatedly asked R4 to stand up to stand up. R4 would start to stand up and at first respond appropriately to NA's questions then quickly demonstrated disorganized thought patterns by changing the topic and go into non-sequential jumbled speech. NA-A asked, questions such as, "Are you ready for lunch?, Do you want some coffee? Do you want to go for a walk?" R4 responded by saying yes, and then stated phrases that contained "had hands in my pocket back here, going to add money to an account, and his folks were still sitting." After 10 minutes, NA-A stated to R4 she was going to give him some more time and come back later as R4 seemed to become agitated and responses more disorganized. When NA-A got to the door R4 started to stand-up independently. NA-A started the routine over again, with prompts, questions, and cues to get R4 to stand up. At one point R4 started laughing in response to her verbal cue however, when NA-A stated "come with me", R4 when from laughing aggressively responding, "I'M GOING TO!!!" and returned to laughing. R4 continued to speak in disorganized speech patterns and NA-A continued to provide verbal cues and prompts to stand-up. At 11:05 a.m. 21	F 600		

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F 600	Continued From page 6	F 600		

minutes later, R4 stood up and was provided multiple more verbal cues to walk down to the dining room with NA-A.

From 11:12 a.m. to 12:50 p.m. R4 sat at the dining room table, at 12:50 p.m. R4 sat with another male resident at the table. There were no staff present at this time and the male resident was not conversing with R4. At 3:18 p.m. R4 sat in the same dining room chair. An activity was going on, R4 watched the activity and intermittently engaged in the activity. At 4:18 p.m. the activity continued and R4 continued to watch. After the activity was finished R4 remained in the chair, the evening meal was served, R4 required staff assistance to eat. After the evening meal another activity started in the same area. R4 watched the activity. After that activity R4 continued to sit in the chair until 8:15 p.m. when an unidentified NA attempted to get R4 to stand up. R4 did not respond to verbal cues to stand. registered nurse (RN)-A assisted the NA. R4 became agitated, however, was calmed by staff. R4 required extensive assistance from both staff to stand up from the chair, once standing, required physical assist from both staff to maintain balance. A wheelchair was provided for R4 and NA brought R4 to his room at 8:30 p.m. RN-A indicated that was not typical for R4 to require physical assist to stand in the evening and usually got up and walked around on his own.

During an interview on 2/10/19, at 12:10 p.m. trained medication assistant (TMA)-A stated she had not witnessed the abusive behaviors, however had knowledge that R4 took pictures off of a resident's wall. TMA-A indicated R4 wandered a lot into resident rooms, and stated some days were better than others. TMA-A was

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not able to articulate what caused R4's behaviors, but they were not predictable. She thought when R4 wandered he was looking for his wife. TMA-A indicated everything had to be done on his terms and staff were attempt to redirect and/or distract R4.

During an interview on 2/10/19, at 12:22 p.m. licensed practical nurse (LPN)-A stated they tried redirection and distraction for R4 which usually worked otherwise we would leave him alone and re-approach later.

During an interview on 2/10/19, at 1:09 p.m. DON indicated R4 had behavioral issues that intensified after admission and his behaviors became increasingly difficult to manage. DON stated R4 had a lot of memory loss and sun downing, was nice and pleasant during the day. DON indicated during the first few weeks it was ok, although R4 wandered into resident's rooms. DON stated sometime in January started we started seeing more of the sun-downing and became more and more difficult to redirect. DON reviewed the VA reports and stated after the first incident we moved him to a hallway where there was no other residents and he was closer to the nursing station. DON stated the move to another room didn't detour R4 from wandering into resident's room so we implemented the stop signs. DON indicated the facility had implemented more activities in the evening hours to help keep R4 occupied and engaged. DON indicated the physician had attempted adjusting his medications, but he would still get aggressive despite the interventions the facility put into place.

During an interview on 2/10/19, at 4:19 p.m. administrator indicated an awareness of R4's

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F 600	Continued From page 8 wandering and abusive behaviors. ADMIN stated the facility was working on paperwork from the county for a transfer to dementia unit. ADMIN confirmed he had a meeting with R4's family and the goal was to keep R4 occupied. Facility policy Abuse Prevention Program dated 8/2006, included: our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. 1) our facility is committed to protecting our residents from abuse by anyone including but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law	F 609		3/27/19

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provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the State agency (SA) were notified within 2 hours of allegations of physical abuse, following two separate resident to resident altercations initiated by R4 for 2 of 5 residents (R6, R7) resident allegations reviewed. In addition, 2 of 2 resident (R1, R5) with injuries of unknown origin.

Findings include:

RESIDENT TO RESIDENT
R4's facility face sheet indicated R4 was admitted to the facility on 12/18/19, with diagnosis of dementia without behavioral disturbance however, on 12/27/18, dementia with behavioral disturbance was added.

R4's Minimum Data Set (MDS) dated 1/15/19, continued to reflect the same levels of cognition, signs and symptoms of delirium, and absence of hallucinations/delusions as the aforementioned assessments. The MDS indicated a change in behavioral symptoms that included: R4 had physical and verbal behaviors that were directed at others one to three days during the

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Identified incidents regarding R4 involving R6 and R7 were reported late. The injuries of unknown origin were also reported late regarding R1 and R5

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents progress notes reviewed over last 30 days and no other reportable events noted

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.

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F 609	Continued From page 10 assessment period, increase in wandering behaviors from one to three days to four to six days during the assessment period. The MDS also indicated R4 had rejection of care behaviors one to three days. The MDS also indicated R4 was administered an antipsychotic medication for 6 days, and antianxiety medication on 4 days. The MDS indicated the level of care for activities of daily living had increased: For Bed mobility, transfers, walk in room and corridor, locomotion on and off the unit, dressing and toilet use required extensive assistance from two or more staff members. R6's significant change MDS 11/21/18, indicated R6 had moderate cognitive impairment. The MDS also indicated R6 required supervision with set-up help for transfers and locomotion on and off the unit, and did not ambulate. Review of a Vulnerable Adult (VA) report dated 1/31/19, indicated an incident of resident-to resident physical abuse occurred. The incident report indicated R4 pushed R6 in a wheelchair into a mechanical lift in the hallway and was hitting R6 on top of the head with his fist. According to the report. the incident occurred at 12:00 a.m., but had not reported to the state agency until 11:06 a.m., over 11 hours later. The investigative summary dated 2/7/19, indicated R4 behavior's seemed to escalate when being redirected. R6 who was hit had no bruising. The provider has reviewed R4's medications and altered for improvement of mood/behavior and was in the process of moving to a facility with a memory care unit. The summary indicated the actions to prevent reoccurrence to other residents included distractive activities every evening for R4	F 609	Education with all staff regarding identifying reportable events to include resident to resident altercations, allegations of abuse, neglect, misappropriation, exploitation and injuries of unknown origin and the need to update the DON and NHA immediately. DON, prior NHA and current NHA educated regarding reporting all mandated reportable events within the timeframe of 2 hours after incident was identified. DON/NHA will report all reportable events to the RCD for review. How the facility plans to monitor its performance to make sure that solutions are sustained. RCD will audit all self-reports submitted by the center over next 60 days to ensure the center was in compliance with the regulated time frame. All self-reports will be reviewed at QAPI.	

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has been helpful to reduce behavior; such as pushing cars instead of pushing other residents in wheelchairs.

R7's quarterly MDS dated 1/10/19, indicated R7 did not have cognitive impairment. The MDS also indicated R7 required extensive assistance from one staff member for transfers and ambulated with supervision.

Review of R7's record included a progress note dated 1/10/19, at 7:30 a.m. included, "resident reported other resident [R4] wandered into her room" and she told him to leave and he tried to taker her slippers. resident stated loudly "those are my slippers" and took them from R4. R7 reported R4 hit her on the left side of her head. R7 states it did not hurt, "just startled her". A follow up progress note dated 1/10/19, at 8:35 a.m. indicated no injuries as a result of the incident.

Review of the facility's Vulnerable Adult reports lacked evidence the resident-to-resident abuse that involved R7 was reported to the State Agency.

INJURY OF UNKNOWN ORIGIN
R1's quarterly MDS dated 12/13/19, indicated R1 had severe cognitive impairment. The MDS indicated R1 was totally dependent on two or more staff for bed mobility, transfers, locomotion, and toilet use. In addition, the MDS indicated R1 had functional limitation in range of motion to both upper and lower extremities.

R1's Bi-monthly summary dated 1/13/19,

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F 609	Continued From page 12 indicated R1 required a Hoyer (full body mechanical lift) with two persons. The summary did not indicate what size sling to use for R1. R1's progress note dated 1/31/19, at 9:57 p.m. indicated R1's bridge of nose was bruised, slight bruising under left eye upon assessment. Physician assistant was in at the time to assess and was asked to reassess because writer was going to transfer care for x-ray of possible fracture of the nose. Orders for x-ray were given and director of nursing and power of attorney were notified. A subsequent progress note at 11:17 p.m. indicated Mobile Medical was scheduled for 8:00 a.m. on 2/1/19. A vulnerable adult (VA) report to the State Agency (SA) dated 2/1/19, indicated the report was made for allegations of physical abuse, however was not reported until the next day on 2/1/19, at 3:41 p.m. The report indicated the incident occurred on 1/31/19, at 12:21 a.m. The report indicated R1 had slight redness to her nose area with mild bruising appearing. No notes with cause and no known time, and an x-ray was obtained. The investigative report submitted to the SA on 2/7/19, indicated R1 had a nose fracture. The report included: Upon investigating it was found that this particular Hoyer being used for this patient has padded cross bar on the Hoyer sits horizontally along the plane of where her nose is. The bruising is in the exact place where this cross bar is as her face seems to be inches away from this bar while being raised. A different type of Hoyer should be used with this resident. This particular Hoyer is not to be for this resident. Re-education with staff to move residents slowly and to be watchful of how they are moving R1.	F 609		

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R5 facility, undated, Admission Record included diagnosis quadriplegia, traumatic brain injury, paralytic syndrome, tracheostomy, cramp and spasm, and convulsions.

R5's admission Minimum Data Set (MDS) dated 1/15/19, indicated R5 did not have speech, rarely/never made himself understood, and rarely/never understood others. The MDS indicated R5 had severe cognitive impairment. The MDS indicated R5 was totally dependent on two or more staff for bed mobility and transfers.

R5's activities of daily living care plan initiated on 1/30/19, indicated for transfers R5 required total assistance of two staff with mechanical aide Hoyer.

R5's progress note dated 1/31/19, at 12:04 a.m. included, family member (FM)-E "came in tonight and called me into resident's room and was looking him over. Resident was very stiff and his right foot was bright red and toes are going in a different direction, concerned of a fracture." FM-E stated this was probably from the lift machine was in and must have gotten caught in the sling and no one said anything. DON (director of nursing) waiting for an order from the on call doctor for the mobile x-ray to come and do an x-ray.

A vulnerable adult report (VA) submitted the state agency on 2/1/19, for allegations of neglect, that occurred on 1/31/19, at 5:00 p.m. and reported to the state agency on 2/1/19, at 4:37 p.m. Description of injury was "unsure possible lift injury." The report indicated a family member had noticed R5's right big toe was crooked and

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expressed concern that it may be broken, toe slightly reddened, and an X-ray ordered. The investigative summary dated 2/7/19, at 12:01 p.m., included no one was quite sure exactly what happened. Resident chair leans back and has foot pedals. Feet seem to want to position in between peddles, upon lifting with Hoyer (full body mechanical lift) his toe may have gotten stuck between the pedals. No fracture, soft tissue injury, possible sprain identified. The report indicated staff were provided with re-education on mechanical lift policy and to be observant of where extremities are when moving the resident; facility policy was updated to reflect. There was no indication of what possibility occurred.

During an interview on 2/10/19, at 1:10 p.m. director of nursing DON verfied R6's VA report was submitted late to the SA, and should have been reported within 2 hours. DON stated that R7's incident was reported late and was combined with R6's VA report; DON confirmed the report to the SA on 1/31/19, was not thorough and did not include R6's name or description of incident. DON also reviewed and verified the allegation of physical abuse for R1 and R5 was not submitted within 2 hours of the allegation and should have been.

Facility policy Abuse Investigation and Reporting dated 7/2017, included: all reports of resident willful abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of willful abuse

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F 609	Continued From page 15 investigations will also be reported. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury 5. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		3/27/19

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F 610	Continued From page 16 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 allegations of resident to resident physical abuse were thoroughly investigated for 1 of 2 residents (R7) reviewed for resident to resident physical altercations by R4. Findings include R4's facility face sheet indicated R4 was admitted to the facility on 12/18/19, with diagnosis of dementia without behavioral disturbance however, on 12/27/18, dementia with behavioral disturbance was added. R4's scheduled MDS dated 1/15/19, continued to reflect the same levels of cognition, signs and symptoms of delirium, and absence of hallucinations/delusions as the aforementioned assessments. The MDS indicated a change in behavioral symptoms that included: R4 had physical and verbal behaviors that were directed at others one to three days during the assessment period, increase in wandering behaviors from one to three days to four to six days during the assessment period. The MDS also indicated R4 had rejection of care behaviors one to three days. The MDS also indicated R4 was administered an antipsychotic medication for 6 days, and antianxiety medication on 4 days. The MDS indicated the level of care for activities of daily living had increased: For Bed mobility, transfers, walk in room and corridor, locomotion on and off the unit, dressing and toilet use required extensive assistance from two or more staff members.	F 610	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Investigations completed regarding the identified issue with R4 and R7 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents progress notes reviewed over last 30 days and no other reportable events noted What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education with all staff regarding identifying reportable resident to resident altercations which included verbal, physical and sexual and the need to update the DON and NHA immediately. DON and prior NHA educated regarding reporting and conducting a complete investigation regarding resident to resident altercations. New concern report/self-report check list initiated to assist DON and NHA with completing a full investigation.	

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Review of R4's record included a progress note progress note dated 1/9/19, at 8:17 p.m. included, R4 hit another resident, R7 in that resident's room. R7 stated it didn't hurt her. The two residents were separated by staff and made the nurse aware. Writer made the resident power of attorney and director of nursing aware of the situation. Incident did not result in injury to either resident. R4 was put to bed and he would be continued to be monitored.

R7's quarterly MDS dated 1/10/19, indicated R7 did not have cognitive impairment. The MDS also indicated R7 required extensive assistance from one staff member for transfers and ambulated with supervision.

Review of R7's record included a progress note dated 1/10/19, at 7:30 a.m. included, "resident reported other resident [R4] wandered into her room she told him to leave and he tried to taker her slippers. resident stated loudly "those are my slippers" and took them from him. She reports he hit her open palm on the left side of her head. She states it did not hurt, just startled her". A follow up progress note dated 1/10/19, at 8:35 a.m. indicated no injuries as a result of the incident.

A Vulnerable Adult (VA) report dated 1/31/19, included a resident-to-resident physical abuse involving R4 and R7. The report investigative summary on 2/7/19, included: resident has had more than one occurrence of hitting other residents (the report did not identity who the other residents were) and also has hit staff.

During an interview on 2/10/19, at 1:10 p.m. director of nursing (DON) confirmed the

Provider's plan of correction:

How the facility plans to monitor its performance to make sure that solutions are sustained.

RCD will audit all identified resident to resident altercations over the next 60 days to ensure a full complete investigation was conducted. All audits and self-reports will be brought to QAPI for review and to determine any further follow up needed.

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F 610	Continued From page 18 resident-to-resident abuse incident investigation had not been completed and should have been. Facility policy Abuse Investigation and Reporting dated 7/2017, included: all reports of resident willful abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. 5. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident	F 610		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor, and identify signs and symptoms of dehydration for 1 of 3 residents (R3), who displayed signs and symptoms of a gastrointestinal illness and was admitted to the hospital for dehydration. The facility's failure resulted in actual harm to R3	F 684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R3 was sent to the hospital prior to the survey	3/27/19

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F 684	Continued From page 19 when the resident required hospitalization for dehydration. Findings include: R3's hospital discharge summary dated 1/25/19, indicated R3 was admitted to the hospital on 1/22/19. The summary included the reason for hospital admission was hypernatremia and dehydration. Hospital course indicated prior to admission R3 had suffered nausea, vomiting and diarrhea and was found to be hypernatremic in the emergency room where he was treated with intravenous fluids. R3's facility Admission record included dementia without behavioral disturbance, gastro-esophageal reflux disease, and dysphagia. R3's annual Minimum Data Set (MDS) dated 12/16/18, indicated R3 had severe cognitive impairment. The MDS also indicated R3 was occasionally incontinent of bowel and was not on a diuretic medication. R3's nutrition care plan dated 7/31/18, included alteration in nutrition/hydration with the associated goal will consume 1600 milliliters (ml) of fluid per day (6 cups). Interventions included administer medications as ordered, observe effects on food intake. R3's historical physician orders included: offer 4 ounces of water or sugar free beverage three times per day with a start date of 10/30/18, and stop date of 1/29/19. Physician orders did not indicate R3 was on a fluid restriction and/or scheduled laxatives. R3's bowel movement record from 1/1/19 through	F 684	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents progress notes reviewed over last 30 days and other residents having nausea, vomiting or diarrhea leading to signs of dehydration. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. DON educated on clinical review process prior to the IDT clinical meeting. During review any residents having a change of condition including N/V/D will be reviewed and interventions will be implemented if deemed necessary. All nursing staff educated to report any resident having loose stools or emesis. A full nursing assessment should be completed and documented every shift following a change of condition until resolved. DON and nursing staff educated on how to handle an outbreak. RCD created an outbreak manual for all nursing staff to follow in the event of an outbreak that walks them through step by step. How the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 684	Continued From page 20 1/22/19, indicated R3's was continent of bowel and had formed stools one episode of incontinence with watery/loose stool on 1/4/19. The record indicated R14 had a change in bowel pattern that began on 1/14/19: -On 1/14/19, at 1:00 p.m. R3 was incontinent of large loose/water stool and was incontinent and at 1:34 p.m. had another incontinent episode of medium loose/watery stool. -On 1/15/19, at 3:05 a.m. R3 was incontinent of large putty like stool and at 10:00 a.m. was incontinent of medium loose/water stool -On 1/16/19, at 12:52 p.m. R3 was incontinent of medium loose/watery stool, and at 8:04 p.m. was continent of large loose/water stool. -On 1/17/19, at 12:58 p.m. R3 was incontinent of large loose/watery stool, at 8:46 p.m. was continent of medium loose/water stool. -On 1/18/19, at 1:09 p.m. R3 was incontinent of medium loose/watery stool -On 1/19/19, at 1:37 p.m. R3 was incontinent of large loose/watery stool, and at 8:06 p.m. was continent of small loose/water stool. -On 1/20/19, at 1:43 p.m. R3 was continent of large loose/watery stool. -On 1/21/19, at 1:25 p.m. R3 was incontinent large loose/watery stool, at 9:41 p.m. was continent of small formed normal stool. R3's vital sign record indicated although R3 had several loose stools (blood pressure, heart rate, and temperature) were not monitored during the time R3 demonstrated signs and symptoms of illness. Prior to R3's last recorded vital signs were documented on 1/7/19. R3's January Medication Administration Record (MAR) reflected the physician order to offer 4 ounces of water three times a day. The MAR	F 684	RCD will audit progress notes, alert charting and IDT notes weekly for 5 weeks to ensure that all change of conditions are followed up on correctly and have a thorough nursing assessment.	

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included boxes that were either coded that R3 did not receive the water or an amount. Based on the documentation from the fluid intake record it could not be ascertained if the fluid documented on the MAR was combined with the totals from the fluid intake record.
R3's documented fluid intake record reviewed from 1/14/19, through 1/21/19 included
-1/14/19, total intake 720 ml -MAR indicated no additional fluid.
-1/15/19, total intake 720 ml -MAR included 120 ml
-1/16/19, total intake 530 ml -MAR included 100 ml
-1/17/19, total intake 580 ml -MAR included 120 ml
-1/18/19, total intake 600 ml -MAR indicated no additional fluid
-1/19/19, total intake 720 ml -MAR indicated no additional fluid
-1/20/19, total intake 600 ml -MAR indicated no additional fluid
-1/21/19, total intake 240 ml -MAR indicated no additional fluid

R3's fluid intake record was reviewed from 1/14/19, through 1/22/19; the record lacked evidence R3's fluid balance was evaluated for fluid balance and/or lacked evidence R3 was assessed and monitored for dehydration. The record further lacked evidence fluids were encouraged and/or increased to maintain hydration.

R3's progress note dated 1/21/19, at 1:36 a.m. indicated R3 had several loose foul smelling bowel movements since Thursday night 1/17/19, three emesis on the shift. R3 had been in bed all shift in discomfort and no appetite. The note

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indicated standing orders with Mylanta and clear liquid diet. Called on call doctor to obtain a stool sample.

R3's progress note dated 1/21/19, at 4:04 p.m. indicated R3 had not had any loose stools and temperature was 97.8. A subsequent progress note at 4:30 p.m. indicated R3 felt better and abdomen was not hurting, and would continue to monitor stool.

R3's physician note dated 1/22/19, indicated reason for special visit was because R3 had nausea, vomiting, and diarrhea for three days. The note included, "started with nausea vomiting and diarrhea on Friday, 1/18 into Saturday 1/19. Several loose stools initially and have since slowed down. He continued vomiting into Monday morning 1/21. Oral intake has been minimal, even for him eating snacks and minimal liquid intake. No vomiting or diarrhea today but is noted to appear more tired than normal." Physician notes indicated that vital taken today (1/22/19) R3 had low grade temp of 99.6, elevated pulse to 130's, oral fluids offered but he only took sips. The physician included diagnosis of dehydration and plan was to send to the emergency room.

R3's progress note dated 1/22/18, at 3:15 p.m. indicated R3 was admitted to the hospital for hypernatremia and dehydration.

During an interview on 2/10/19, at 12:22 p.m. licensed practical nurse (LPN)-A indicated there was an gastrointestinal illness a few weeks ago that effected several residents. LPN-A confirmed R3 was admitted to the hospital for dehydration. LPN-A reviewed and confirmed the R3 record lacked monitoring of vital signs and for signs and

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symptoms of dehydration. Anna stated the physician should have been contacted.

During an interview on 2/10/19, at 3:22 p.m. director of nursing (DON) confirmed there was a gastrointestinal outbreak in the facility a few weeks ago and R3 had been admitted to the hospital for dehydration. DON reviewed R3's record and confirmed the lack of monitoring during acute period of illness. DON indicated that the physician should have been notified sooner than 1//22/19.

During an interview on 2/10/19, at 6:33 p.m. physician assistant (PA)-A indicated the facility had a norovirus outbreak which started on 1/18/19, providers were not notified until 1/22/19. PA indicated on 1/22/19, she reviewed R3's record and found R3's record lacked documentation of monitoring of vital signs and signs and symptoms of dehydration. PA-A stated when a nurse obtained vital signs he was tachycardiac with his heart rate in 130's, which was above R3's baseline. PA-A indicated she had R3 transferred to the hospital where he was found to be hypernatremic with sodium level of 155, and was dehydrated. PA-A stated the nurses should have identified R3 had a change in condition, notify the provider, and have monitored vital signs and symptoms of dehydration.

Facility policy Change in Resident's Condition or Status dated 1/2019, included: Our facility will promptly notify the resident his or her attending physician and representative of changes in the resident's medical/mental condition and/or status.
1. The nurse will notify the resident's attending physician or physician on call when there has been a) accident or incident involving the

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F 684	Continued From page 24 resident. b) discovery of injuries of an unknown source. d) significant change in the resident's physical/emotional/mental condition. e) need to alter the resident's medical treatment significantly. i) specific instruction to notify the physician of changes in the resident's condition. 3. Prior to notifying the physician or healthcare provider the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact change of condition tool. 5. Except in medical emergencies notifications will be made within twenty-four hours of a change in the resident's medical/mental condition or status. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess safe transfer requirements for 2 of 2 residents (R1 and R5) whom were injured during transfers. This resulted in actual harm for R1 whom received a facial fracture during her transfer with a mechanical lift.	F 689	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R1 and R5 care plans updated with appropriate mode of transfer including	3/27/19

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F 689

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Findings include:

R1's quarterly Minimum Data Set (MDS) dated 12/13/18, indicated R1 had severe cognitive impairment. The MDS indicated R1 was totally dependent on two or more staff for bed mobility, transfers, locomotion, and toilet use. In addition, the MDS indicated R1 had functional limitation in range of motion to both upper and lower extremities.

R1's care plan dated 2/1/18, indicated R1 has limited physical mobility related to Alzheimer's, was non-weight bearing, and required one assist for locomotion. The care plan also directed staff to provide supportive care, assistance with mobility as needed and document assistance as needed. R1's care plan did not identify how R1 transferred.

R1's progress note dated 1/30/19, at 10:41 p.m. indicated the nursing assistant called the nurse into R1's room to show her R1's face. Upon assessment of face, slight pink area on bridge of nose, resident shows no apparent signs of pain or injury and would monitor the issue.

R1's progress note dated 1/31/19, at 9:57 p.m. indicated R1's bridge of nose was bruised, slight bruising under left eye upon assessment. Physician assistant was in at the time to assess and orders for x-ray were received for possible nose fracture. A subsequent progress note at 11:17 p.m. indicated Mobile Medical was scheduled for 8:00 a.m. on 2/1/19.

The progress note 2/1/19, at 3:02 p.m. (late entry from 2/4/19, at 3:05 p.m.) indicated the x-ray

F 689

sling type.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents that transfer with mechanical lift have the potential to be at risk, hoyer assessment completed on all residents to ensure proper sling is in use. Care plans updated as appropriate

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.

Mechanical lift education from the manufacture guidlines with competency checks completed with all staff that operate the lifts. New hoyer assessment created in PCC to assist staff with assigning proper sling to resident. Education to nursing staff included the lift type and sling type needing to be on the care plan and to only use those that are appropriately care planned. Education completed with staff to monitor the residents head and extremities to ensure no injury occurs.

How the facility plans to monitor its performance to make sure that solutions are sustained.

DON/designee will complete 2 care plan audits a week for 4 weeks of residents that use a mechanical lift for transferring

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F 689	Continued From page 26 results showed that R1's nose was fractured and recommended that the resident have a CT scan to further look at the nose. Family notified and didn't think the CT scan was necessary. R1's vulnerable adult (VA) report to the State Agency (SA) dated 2/1/19, at 3:41 p.m. indicated the incident occurred on 1/31/19, at 12:21 a.m. The report indicated R1 had slight redness to her nose area with mild bruising appearing. No notes with cause and no known time. The investigative report submitted to the SA on 2/7/19, included: Upon investigating it was found that this particular Hoyer being used for this patient has padded cross bar on the Hoyer sits horizontally along the plane of where her nose is. It looks like the bruising is in the exact place where this cross bar is an her face seems to be inches away from this bar while being raised. Staff were negligent in ensuring that the resident didn't lean to far over where her face struck the cross bar on the Hoyer. A different type of Hoyer should be used with this resident. This particular Hoyer is not to be for this resident. Re-education with staff to move residents slowly and to be watchful of how they and their extremities are moving R1's record lacked evidence of a comprehensive safe-transfer mechanical lift assessment and/or the care plan lacked identification of what type and sling size R1 required for her transfer. R5's facility Admission Record included diagnosis quadriplegia, traumatic brain injury, paralytic syndrome, tracheostomy, cramp and spasm, and convulsions.	F 689	to ensure all appropriate information is correct. DON/designee will also complete 2 competency checks each week for 4 weeks to verify that the nursing staff are using the correct lift and sling. All audits will be brought to QAPI for review and to determine the need for further follow up.	

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R5's admission Minimum Data Set (MDS) dated 1/15/19, indicated R5 did not have speech, rarely/never made himself understood, and rarely/never understood others. The MDS indicated R5 had severe cognitive impairment. The MDS indicated R5 was totally dependent on two or more staff for bed mobility and transfers.

R5's Interim Care Plan dated 1/2/19, indicated R5 required a mechanical lift for transfers. R5's activities of daily living care plan initiated on 1/30/19, indicated for transfers R5 required total assistance of two staff with mechanical aide Hoyer.

A vulnerable adult report (VA) submitted the state agency on 2/1/19 at 4:37 p.m. indicated the time of incident was 1/31/19, at 5:00 p.m. Description of injury was "unsure possible lift injury." The report indicated a family member (FM)-E noticed R5's right big toe was crooked and expressed concern that it may be broken, toe slightly reddened, and an X-ray ordered. The investigative report dated 2/7/19, at 12:01 p.m., included "no one was quite sure exactly what happened. Resident chair leans back and has foot pedals. Feet seem to want to position in between peddles, upon lifting with Hoyer (full body mechanical lift) his toe may have gotten stuck between the pedals. No fracture, soft tissue injury, possible sprain. The report indicated staff were provided with re-education on mechanical lift policy and to be observant of where extremities are when moving the resident; facility policy was updated to reflect.

R5's record lacked evidence of a comprehensive mechanical lift safe-transfer assessment and/or the care plan lacked identification of what type

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and sling size required for R5.

During an interview on 2/10/19, at 1:10 p.m. director of nursing (DON) stated both of the incidents happened almost at the same time, however, R1's injury happened first. DON stated she received a phone call from a nurse the evening of 1/30, about R1's nose being red, and then the evening of 1/31, she got a call that reported there was more bruising. Stated on 2/1, she went in to watch a transfer with R1 using the lift, and that the crossbar of the lift aligned with R1's nose because R1 bent at the waist (curled in a fetal position), and more than likely hit the bar during a transfer. DON stated she removed the lift that caused injury to R1's nose from use in order to prevent further incidents and provided on the spot education about ensuring proper positioning and awareness of extremities.

DON indicated R5's foot might have been caught on his wheelchair or bed sheet. DON then stated she revised the facility policy on mechanical lifts to include positioning and proper lifting techniques pertaining to extremities. DON indicated she educated staff on 2/3 on the revision to the policy. DON confirmed there was not a record of attendance and/or competency completed to use the mechanical lifts. DON stated she had watched a few lift transfers since the time of the injuries however, did not have record of dates and times. DON stated, she also added to the policy to watch extremities. DON stated she planned on completing audits to ensure staff followed the policy for safe transfers.

During an interview on 2/10/19, at 6:33 p.m. physician assistant (PA)-A stated she would expect the facility to ensure staff provide safe

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F 689	Continued From page 29 transfers for the residents. PA-A indicated the injuries that R1 and R5 sustained were consistent with poor transfer techniques. Undated facility policy Champion Care Safe Resident Handling Policy included: To enhance the safety of the work environment for resident care providers and promote a safe, secure and comfortable experience for residents who require partial moving or full transfer assistance while keeping employees safe. The purpose of this program is to reduce the incidence and severity of employee and resident injuries related to resident transfers and repositioning. Evaluation and resident assessment: interdisciplinary team (IDT- or representative) will evaluate and assess each resident's mobility needs Resident mobility assessments will be performed or reviewed on admission, quarterly, after a significant change in condition or based on direct care staff recommendations. 4. Staff members providing direct resident care trained on general safe resident handling specific resident mobility and specific resident techniques upon hire and annually. -Ongoing training on new and improved techniques of patient/resident handling and movement will be provided and identified.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:	F 744		3/27/19

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Based on observation, interview, and document review the facility failed to provide person centered dementia care for 1 of 1 residents (R4) who demonstrated an escalation of dementia related behaviors which included wandering and threatening aggressive behaviors after admission to the facility.

Findings include

R4's facility face sheet indicated R4 was admitted to the facility on 12/18/19, with diagnosis of dementia without behavioral disturbance however, on 12/27/18, dementia with behavioral disturbance was added.

R4's scheduled Minimum Data Set (MDS) dated 12/25/18, indicated R4 had severe cognitive impairment with signs/symptoms of delirium that included inattention and disorganized thinking behaviors that did not fluctuate and were continuously present. The MDS indicated R4 did not have hallucination or delusions, did not have verbal or physical behaviors, however, had rejection of care behaviors and wandering behaviors (that did not impact resident or others) one to three days during the assessment period. The MDS indicated R4 required antipsychotic medications. The MDS indicated R4 required extensive assistance from two staff for transfer, dressing, locomotion off the unit, and toilet use, and for walking in room supervision and corridor with assistance of two or more staff, and supervision on one staff for locomotion on the unit.

R4's Clinical Follow-up dated 12/21/18, included Alert, wandering. Unable to have conversation d/t disorganized thinking and slurred speech.

F 744

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

R4 was discharged from the center the day after the survey

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents that exhibit behaviors have the potential to be affected. All residents reviewed and any residents identified with having dementia or behaviors had care plan updates including target behaviors to provide more person centered dementia care. A behavior evaluation was completed on all current residents that demonstrate behaviors.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.

Care plans updated to include target behaviors that will trigger documentation from all nursing staff. All current residents specific target behaviors entered along with resident specific interventions. All staff educated regarding target behaviors and how to document appropriately. All staff education included how to create and maintain a person-centered care plan. DON to audit charts M-F during the

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Looking for wife this AM. Able to be redirected

R4's admission MDS dated 1/1/19, continued to reflect the same levels of cognition impairment, and signs symptoms of delirium as the aforementioned MDS. The MDS further indicated no hallucination/delusions, no verbal, physical, or rejection behaviors, and wondering behaviors one to three days during the assessment period that did not impact resident or others. The MDS indicated 4 continued to require antipsychotic medications. The MDS indicated a change in level of assistance for the following: For walking R4 required supervision with assistance of one staff, supervision with one assist for toilet use, walking in corridor and locomotion off the unit.

R4's behavioral symptom Care Area Assessment dated 1/4/19, indicated R4 had wondering behaviors. The CAA lacked a comprehensive analysis and included "Resident has behaviors of wondering. Will proceed to the care plan."

R4's scheduled MDS dated 1/15/19, continued to reflect the same levels of cognition, signs and symptoms of delirium, and absence of hallucinations/delusions as the aforementioned assessments. The MDS indicated a change in behavioral symptoms that included: R4 had physical and verbal behaviors that were directed at others one to three days during the assessment period, increase in wandering behaviors from one to three days to four to six days during the assessment period. The MDS also indicated R4 had rejection of care behaviors one to three days. The MDS also indicated R4 was administered an antipsychotic medication for 6 days, and antianxiety medication on 4 days. The MDS indicated the level of care for activities

clinical review process including the 24-hour report, alert report and new behaviors. All behaviors will be brought to the daily clinical meeting M-F where IDT will review and implement any new interventions needed. IDT educated on reviewing behaviors and completing the behavior evaluation in PCC at least quarterly and with change of condition.

How the facility plans to monitor its performance to make sure that solutions are sustained.

RCD will audit progress notes, alert charting and IDT notes weekly for 5 weeks to ensure any new behaviors or new residents with dementia were reviewed and have a person centered dementia care plan in place.

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of daily living had increased: For Bed mobility, transfers, walk in room and corridor, locomotion on and off the unit, dressing and toilet use required extensive assistance from two or more staff members.

R4's record lacked a comprehensive assessment of the behaviors identified on the MDS.

R4's physician orders included:
-Seroquel 12.5 milligrams (mg) by mouth at bedtime for dementia for 7 days. (start date 12/18/19, stop date 1/11/19)
-Ativan 0.5 mg as needed for anxiety/restlessness (start date 1/7/19, stop date 1/15/19)
-Seroquel 50 mg once daily on p.m. med pass (start date 1/12/19, stop date 1/14/19)
-Seroquel 25 mg at bed time for dementia sun downing (start date 1/14/19). Seroquel 25 mg at noon was added to the regimen on 1/16/19.
-Target Behaviors for use of Seroquel: Wandering around facility, and yelling at staff/residents Interventions: #1 Talk 1:1 with resident about family or what is making him upset #2 Offer a snack #3 walk with resident (start date of 12/20/18, and stop date of 12/27/18)

R4's Behavior care plan initiated on 1/11/19, indicated R4 had behavioral problem related to wondering, physically abusive, disruptive, and dementia, with goal of behaviors will not cause harm to self or others. The care plan interventions dated 1/11/19, included
-Assess pattern, intensity, and duration of the problem behavior. Attempt to determine if behavior is associated with particular events. Assess for recent medication changes, change in environment as possible causes.

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F 744	Continued From page 33 -Provide calm reassurance, redirection, or distractions and assess effectiveness. Provide positive reinforcement for appropriate behaviors. Confront gently and respectfully when behavior is inappropriate and set limits. Share effective interventions with other staff members. -Maintain a routine and stress free environment as possible, keep noise to a minimum. Encourage activities and socialization. -Include and/or responsible party in treatment plan. Notify physician and update as indicated by change in condition treatment. R4's psychotropic care plan initiated on 1/7/19, indicated R4 required Seroquel related to behavioral management-dementia, corresponding interventions at the time care plan was initiated included monitoring for side effects and effectiveness every shift. The care plan was not revised to include target behaviors until 1/17/19. The intervention directed staff to monitor/record occurrence for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/others, ect). and document per facility protocol. R4's December 2018 medication administration record (MAR) identified the physician order for target behavior tracking for 7 days. The documentation only indicated the number of occurrences of the behaviors; documentation did not differentiate which behavior occurred, and or which interventions were successful. R4's record lacked evidence of a comprehensive analysis of the target behaviors and corresponding interventions documented on the DEC MAR. R4's record continued to lack evidence of a comprehensive assessment of	F 744		

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frequency and intensity of behaviors and effectiveness of non-pharmacological behavioral interventions even when R4's behaviors escalated and became verbally and physically abusive towards staff and other residents.

R4's nursing assistant behavior documentation from time of admission through 2/10/19, indicated an escalation of behaviors. Documentation did not include number of occurrences by shift and did not reflect offered and/or attempted interventions. From 12/18/18 through 1/7/19, R4 had almost daily wandering documented and one rejection of care documented. Record indicated that from 1/7/19, through 2/10/19, R7 had documented behaviors of wandering, abusive language, yelling/screaming, grabbing, kicking/hitting, pinching/scratching, spitting, threatening behaviors, pushing, and rejection of care.

R4's progress note dated 12/21/18, indicated R4 was wandering throughout the facility looking for his wife, was able to be redirected, no violent behaviors.

R4's progress note dated 1/5/19, at 8:34 p.m. indicated R4 was redirected several times from going into other resident rooms, especially female resident rooms. R4 paced all night long until around 3:00 a.m., was "NOT" redirectable, and stated inappropriate and sexual comments to staff.

R4's progress note 1/5/19, at 9:47 p.m. included, "resident is becoming more aggressive physical, when trying to redirect resident back to room to put pants on resident grabbed my wrists and wouldn't let go. Called the clinic for a prn [as

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needed] Ativan, Xanax .....was on hold for 30 minutes, resident is now wandering halls with absolutely no pants or brief on.

R4's physician visit dated 1/7/19, indicated R4 was doing okay, staff have been using Ativan every few days to keep him calm. "Just pleasantly confused right now." No behavioral issues or hallucinations. The note indicated good control of his behavioral issues and history of psychosis with low-dose Seroquel 12.5 mg at bedtime, continue Ativan 0.5 mg one time a day as needed.

R4's progress note dated 1/8/19, at 4:51 a.m. included, "resident was at the nurses station, started to undress take his shoes off, I tried to redirect resident to room, he became extremely agitated with me and CNA's [nursing assistants], he then chose some choice words, and then preceded to swing and punched me in the face, resident was given Ativan before this incident occurred."

R4's MAR note dated 1/9/19, at 8:02 p.m. Ativan was administered for wandering in other residents room.

R4's progress note dated 1/9/19, at 8:17 p.m. included, resident hit another resident in that resident's room. The resident said it didn't hurt her. The two residents were separated by staff and made the nurse aware. Writer made the resident power of attorney and director of nursing aware of the situation. Incident did not result in injury to either resident. R4 was put to bed and he would be continued to be monitored.

R4's progress note dated 1/10/19, at 1:52

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indicated the facility contacted R4's family member (FM)-E about hitting another resident; FM-E expressed concern because R4 did not have a history of hitting/aggression. The note indicated FM-E requested an increase in medication however, the facility explained, "that we don't do that because medication can be a form of restraint. We assured her we will be trying various strategies to reduce behaviors."

R4's progress note dated 1/10/19, at 3:57 p.m. indicated a message was left for the physician regarding R4's behaviors. Progress note dated 1/11/19, indicated physician reviewed medication and increased Seroquel to 50 mg, and time was changed to administer in p.m.

R4's progress note dated 1/14/19, at 9:24 a.m. indicated R4 found sleeping on the floor naked this morning, and appeared someone was about to get resident up and had not completed. The note indicated R4 was difficult to arouse. A subsequent note at 2:31 p.m. indicated physician notified about being drowsy after medication change; new order to adjust Seroquel to 25 mg at noon and 25 mg at bedtime.

R4's progress note on 1/14/19, at 8:16 p.m. indicated R4 was administered Ativan for wandering in other residents room. Progress note on 1/15/19, at 5:53 p.m. indicated Ativan administered for wandering in resident rooms. Note dated 1/16/19, at 8:03 indicated PA visit for behaviors and medication management; new orders in chart.

R4's Bi-Monthly Summary dated 1/15/19, included a section for Emotional/Behavioral; The section had check marks in the boxes for

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interferes with cares and wonders. The assessment did not identify the behaviors nor interventions.

R4's progress note dated 1/17/19, at 1:00 p.m. indicated interdisciplinary team met to review changes in Seroquel and continue to monitor behaviors. Care plan was reviewed and changes were made.

R4's progress note dated 1/19/19, at 7:47 p.m. included, "resident found in another resident room getting undressed, tried getting him out the room he grabbed my wrists starting shaking my arms, tried to calm him down. He swung his arm and punched me in the face, another cna was trying to assist."

R4's Daily Skilled Summary dated 1/20/19, indicated R4's decisions poor cues and supervision was required, short term memory impairment, judgment problems, inattentive and disorganized thinking. The assessment also included R4 wandered around and required redirection several times. The assessment did not identify the behaviors and/or interventions.

R4's physician visit note dated 1/22/19, indicate PA followed up on use of antianxiety medication, with new order to decrease Ativan to 0.25 mg daily as needed. Note indicated the improved behaviors with time change of Seroquel.

R4's MAR note dated 1/25/19, at 6:56 p.m. indicated Ativan was administered for wondering into other resident rooms and the dose was ineffective; continued to wander throughout the facility.

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R4's Daily Skilled Summary dated 1/25/19, indicated R4 decisions were poor. The summary documentation indicated R4 was alert and orientated, unable to have meaningful conversation, rarely made self understood, and wandered throughout the facility.

R4's progress note dated 2/2/19, at 9:16 a.m. indicated R4 had been wanting to push people in wheelchairs, some residents don't care for it. The note indicated staff encouraged R4 to push cart around to assist in cleaning up after activities and pushed the snack cart, seemed more content and less aimless wandering.

R4's progress note dated 2/2/19, at 9:59 p.m. indicated R4 was getting undressed in the day room, he was not able to be redirected and became aggressive. The note further indicated another resident's wife came and R4 was approaching the resident's wife; she started screaming.

R4's MAR note dated 2/3/19, at 5:36 p.m. indicated Ativan was administered for wandering in other resident rooms and hitting.

R4's progress note dated 2/4/19, at 11:32 a.m. indicated R4's wife was contacted and verbally agreed to transfer R4 to another nursing home that had a memory care unit.

R4's activity progress note dated 2/5/19, at 7:02 p.m. indicated R4 did well early in the day but was getting more difficult to direct as time went on.

During an observation on 2/10/19, at 10:44 a.m. R4 sat in a recliner chair in his room. Nursing assistant (NA)-A placed a gait belt around R4's

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F 744	Continued From page 39 waist and placed a walker in front of him. NA-A continuously and repeatedly asked R4 to stand up to stand up. R4 would start to stand up and at first respond appropriately to NA's questions then quickly demonstrated disorganized thought patterns by changing the topic and go into non-sequential jumbled speech. NA-A asked, questions such as, "Are you ready for lunch?, Do you want some coffee? Do you want to go for a walk?" R4 responded by saying yes, and then stated phrases that contained "had hands in my pocket back here, going to add money to an account, and his folks were still sitting." After 10 minutes, NA-A stated to R4 she was going to give him some more time and come back later as R4 seemed to become agitated and responses more disorganized. When NA-A got to the door R4 started to stand-up independently. NA-A started the routine over again, with prompts, questions, and cues to get R4 to stand up. At one point R4 started laughing in response to her verbal cue however, when NA-A stated "come with me", R4 when from laughing aggressively responding, "I'M GOING TO!!!" and returned to laughing. R4 continued to speak in disorganized speech patterns and NA-A continued to provide verbal cues and prompts to stand-up. At 11:05 a.m. 21 minutes later, R4 was now stood up and was provided multiple more verbal cues to walk down to the dining room with NA-A. From 11:12 a.m. to 12:50 p.m. R4 sat at the dining room table, at 12:50 p.m. R4 sat with another male resident at the table. There were no staff present at this time and the male resident was not conversing with R4. At 3:18 p.m. R4 sat in the same dining room chair. An activity was going on, R4 watched the activity and intermittently engaged in the activity. At 4:18 p.m.	F 744		

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the activity continued and R4 continued to watch. After the activity was finished R4 remained in the chair, the evening meal was served, R4 required staff assistance to eat. After the evening meal another activity started in the same area. R4 watched the activity. After that activity R4 continued to sit in the chair until 8:15 p.m. when an unidentified NA attempted to get R4 to stand up. R4 did not respond to verbal cues to stand. registered nurse (RN)-A assisted the NA. R4 became agitated, however, was calmed by staff. R4 required extensive assistance from both staff to stand up from the chair, once standing, required physical assist from both staff to maintain balance. A wheelchair was provided for R4 and NA brought R4 to his room at 8:30 p.m. RN-A indicated that was not typical for R4 to require physical assist to stand in the evening and usually got up and walked around on his own.

During an interview on 2/10/19, at 9:43 a.m. nursing assistant (NA)-C indicated R4 had dementia and was combative with cares "he might swing out at you", and wandered around the facility. NA-C indicated when R4 was first admitted he would just wander around and was not combative with cares. NA-C indicated R4 was not aggressive with other residents. NA-C stated when R4 had aggressive behaviors they would try to redirect him or leave him alone. NA-C indicated if he was wandering around, staff would try to get him to sit down and do something.

During an interview on 2/10/19, at 11:13 a.m. NA-B stated R4 wandered around the facility however, it was more on the evening and night shifts. NA-B also indicated R4 seemed more aggressive and combative on the evening/night shift. NA-B indicated she was not aware of

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F 744	Continued From page 41 interventions that evening/night staff would use when he started wandering into resident rooms, because he really didn't do that during the day. NA-B stated there was activities until 6:00 p.m., that staff encouraged R4 to attend to keep him busy. During an interview on 2/10/19, at 12:10 p.m. trained medication assistant (TMA)-A stated there was not one specific staff member assigned to supervise R4. TMA-A indicated she had not witnessed the abusive behaviors, however was aware he had them. TMA-A indicated R4 wandered a lot into resident rooms, and stated some days were better than others. TMA-A was not able to articulate what caused R4's abusive behaviors, behaviors were not predictable, and stated she thought the wandering was stemmed from looking for his wife. TMA-A indicated everything had to be done on his terms. TMA-A indicated staff would attempt to redirect and/or distract R4. TMA-A stated a lot of the behaviors occurred on the evening and overnight shift, and once put into bed, R4 did not always stay in bed. During an interview on 2/10/19, at 12:22 p.m. licensed practical nurse (LPN)-A indicated when R4 was first admitted he wandered around the facility a lot. LPN-A stated then he started to demonstrate aggressive behaviors, and we've tried to adjust his medications. LPN-A indicated R4 was pretty good as long as he was engaged with an activity or kept busy. LPN-A stated when he has wandered around he has asked for his wife. LPN-A stated when he is resistive with cares, staff tried to redirect him, and/or leave him alone and reproach. LPN-A indicated if R4 wandered around staff tried to redirect and/or distract him with an activity.	F 744		

F 744 Continued From page 42 F 744

During an interview on 2/10/19, at 12:43 p.m. NA-B indicated in the evening time he's aggressive , he was a danger to other residents that's why there were stop signs on the doors. NA-B stated she didn't think the stop signs were effective as she had seen R4 go under the stop signs. NA-B indicated staff tried to redirect him and tried to keep him busy.

During an interview on 2/10/19, at 1:09 p.m. DON indicated R4 had behavioral issues that intensified after admission and his behaviors became increasingly difficult to manage. DON stated R4 had a lot of memory loss and sun downing, was nice and pleasant during the day. DON indicated during the first few weeks it was ok, although R4 wandered into resident's rooms. DON stated sometime in January started we started seeing more of the sun-downing and became more and more difficult to redirect. DON reviewed the VA reports and stated after the first incident we moved him to a hallway where there was no other residents and he was closer to the nursing station. DON stated the move to another room didn't detour R4 from wandering into resident's room so we implemented the stop gaits. DON indicated the facility had implemented more activities in the evening hours to help keep R4 occupied and engaged. DON indicated the physician had attempted adjusting his medications, but he would still get aggressive despite the interventions the facility put into place.

Facility policy Behavioral Assessment, Intervention, and Monitoring dated 12/2016, included: 1. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive

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	245499	A. BUILDING ______ B. WING ______	C 02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA REHABILITATION & RETIREMENT CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

(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 744	Continued From page 43 assessments. 2. Residents who do not display symptoms of, or have been diagnosed with a mental, psychiatric psychosocial adjustment or post traumatic stress disorder will not develop a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors that cannot be explained or attributed to specific clinical condition that makes the pattern unavoidable. The policy directed staff to perform comprehensive behavioral assessments and identify and document specific details regarding changes in resident's mental stats, behavior, and cognition. Cause Identification: 1) The interdisciplinary team (IDT) will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change. Management: 1) IDT will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. A) atypical behavior will be differentiated from behavior that is dangerous or problematic for the resident or staff, or behavior that signals underlying distress. 2) The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. 7)Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. 8) Interventions and approaches will be based on	F 744		

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F 744	Continued From page 44 detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes. 11) The director of nursing or designee, will evaluate whether staffing needs have changed based on acuity of the residents and their plans of care. Additional staff and/or staff training will be provided if it determined that the needs of the resident cannot be met with the current level of staff or staffing training. Monitoring: 1) If the resident is being treated for altered mood/behavior the IDT will seek and document any improvements or worsening in the individuals behavior, mood, and function. 3) Interventions will be adjusted based on the impact on behavior and other symptoms, including adverse consequences related to treatment.	F 744		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		3/27/19

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F 755	Continued From page 45 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have a system for accurately transcribing physician orders into the electronic health record (EHR) to prevent and/or reduce the risk for medication errors for 2 of 2 (R8, R2) records reviewed with transcription errors with the potential to effect all 39 residents residing at the facility. Findings include: R8's Admission Record dated 2/10/19, indicated R8 was admitted to the facility on 12/26/18, with diagnoses that included diabetes type II. R8's hospital discharge summary dated 12/26/19, included the following orders: -Lantus (long acting insulin) 5 units; inject under the skin at bedtime -Melatonin (sleep medication) 5 mg by mouth at bedtime. R8's physician orders transcribed into the	F 755	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R8 and R2 had medication regimen review and all orders corrected How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by identified practice. An audit of all resident□s orders over the past 2 months will be reviewed and matched to the MAR. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.	

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F 755 Continued From page 46

electronic health record (EHR) upon admission to the facility on 12/26/18, did not reflect the order for Lantus and the order for Melatonin was transcribed as "Melatonin give on tablet by mouth at bedtime" and did not include a dose to be administered.

R8's physician visit note dated, 1/8/19, included, R8 was a diabetic type 2. In review of discharge paperwork it was noted he was to be on Aspart (short acting insulin) 12 units at bedtime. Transcription error lead him not to receive long acting Lantus since admission (12/26/18. The note included: No increased thirst or hunger, No infection. Per nursing order, he has had finger stick blood sugars completed three times daily, averaging 115-192. Goal blood sugars readings should be 120-160 due to age. The note further included the order to "Re-introduce lower dose of Lantus 2 units daily due to lower glycemic readings at skilled nursing facility"

R8's hand written physician order dated 1/8/19, included the order for Lantus 2 units daily and clarification for Melatonin 5 mg at bedtime.

R8's December and January medication administration record (MAR)'s indicated R8 was not administered Lantus from 12/26/18 through 1/8/19; 14 missed doses. The MAR's also indicated R8 was administered Melatonin however, between 12/26/19 and 1/8/19, there was no indication what dose of Melatonin was administered.

R2's Admission Record dated 2/10/19, included diagnosis of diabetes type 2.

F 755

New process in place in PCC, when a new physician order is obtained the nurse processing needs to but the order in queue and have another nurse double check prior to making it active. All insulins were moved from the TAR to the MAR by RCD. Education with all nurses and TMA□s regarding new process of entering new orders. TMA□s educated to alert the nurse if a medication has not been signed out. Education to nurses included what all needs to be included with a complete medication order.

How the facility plans to monitor its performance to make sure that solutions are sustained.

DON/designee will pull the order summary from the prior day and match it to the written physician orders to ensure all orders were transcribed correctly and completely x 4 weeks. DON/designee will review all new orders from all admissions and compare it to the transcribed orders in PCC to ensure all orders were included as ordered. The missed medication report will be pulled and reviewed each AM with the clinical review process to determine if any medications were not signed out, this is an ongoing process. All audits and findings will be brought to QAPI for review and to determine if further follow up is needed.

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F 755	Continued From page 47 R2's physician visit dated 1/31/19, included: start Lantus long acting insulin, at bedtime with monitoring finger stick blood sugar twice daily at variable times. At this moment R2 is receptive to this plan. R2's handwritten physician orders dated 1/31/19, included Lantus 2 units subcutaneous at bedtime for diagnosis of diabetes type 2 R2's current physician orders provided during the survey included Lantus solution Pen-Injector 100 units/milliliter; inject 2 units subcutaneous at bedtime (start date 1/31/19.) R2's January and February's medication administration record (MAR) did not reflect the order for insulin. However, January and February's treatment administration record (TAR) included the insulin order. The TAR indicated from 1/31 through 2/4/19, Lantus was not administered and 5 doses were missed. R2's record lacked evidence of a reason why the doses were omitted. During an interview with licensed practical nurse (LPN)-A confirmed R2 had missed doses of insulin because the order was transcribed as a treatment and not a medication. LPN-A indicated when orders were received from the physician via verbal, faxed, or written the nurse would transcribe the order into the EHR system and fax the order to pharmacy. LPN-A indicated the progress note would be written that there was a new order, and the order was placed in the paper chart. For verbal orders, the physician would then sign the order during the next visit. LPN-A stated for a new admission or readmission orders were entered into the que and a second nurse would	F 755		

F 755 Continued From page 48 F 755

check the orders, verify, and release the orders from the cue. LPN-A stated routine orders aside from admission/readmission were not transcribed into the que, and/or verified by a second nurse for accuracy. LPN-A stated there was not always two nurses working in order to review and verify transcribed orders.

During an interview on 2/10/19, at 1:10 p.m. director of nursing (DON) indicated a few weeks ago physician assistant (PA)-A brought medication transcription errors to her attention. DON stated orders were missing or not transcribed from the admission/readmission orders. DON indicated since that time, admission/readmission orders were transcribed in the record by one nurse, placed in the que, then another nurse would review, verify, and make the orders active. DON stated there was not a verification system in place for routine orders not associated with admission/readmissions.

During an interview on 2/10/19, at 6:33 p.m. physician assistant (PA)-A stated even though she had brought concerns with medication transcription issues, the problem still seemed to be ongoing. PA-A stated the facility did not have a system in place for checking transcribed orders. PA-A indicated one of the transcribed issues had to do with insulin; it was transcribed onto the treatment administration record, instead of the medication administration record, and since it was entered as a treatment, the insulin was missed.

During an interview on 2/26/19, at 11:53 a.m. consultant pharmacist (CP)-A stated PA-A had contacted him regarding transcription issues that were occurring at the facility. CP-A stated the

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F 755	Continued From page 49 suggestion was to avoid verbal orders and that the facility fax the original handwritten prescription to the pharmacy to ensure the order was correctly dispensed. CP-A indicated even if the facility received a fax prescription and the facility faxed it to the pharmacy, the pharmacy could not control how staff entered it into the residents electronic health record. If the order was entered wrong, however, the prescription was filled correctly, could still result in a medication error. CP-A stated the pharmacist would review monthly physician orders with hand written orders/faxes to ensure the electronic record matched. If the order started off as a verbal order, and if the physician was there on a weekly basis, the order would be wrong for a week if the facility did not have an order verification system in place at the time the ordered was transcribed into the medical record. CP-A stated it was an expectation orders were double checked by nursing.	F 755		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population,	F 838		3/27/19

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F 838	Continued From page 50	F 838		

including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing

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F 838	Continued From page 51 information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to complete a comprehensive facility wide assessment to determine facility needs to ensure an effective plan was in place to maintain the highest practicable care for all 39 residents residing at the facility. Findings include: A facility assessment document was requested during the survey, and no document was received. During an interview on 2/10/19, at 4:19 p.m. Administrator (ADMIN) stated he became the facility administrator at the end of November 2018. ADMIN indicated he had not reviewed and/or developed a facility assessment. ADMIN further indicated a facility assessment was not able to be found in the facility at the time of the survey.	F 838	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? N/A How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. N/A What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Prior and current NHA and DON educated on the process of completing a facility assessment that must be reviewed annually with QAPI. An outline was provided to the DON and NHA to assist with completing the facility assessment. How the facility plans to monitor its performance to make sure that solutions are sustained. RCD will review once completed and	

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F 838	Continued From page 52	F 838	ensure it is reviewing initially and annually at QAPI	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 18, 2019

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

Re: State Nursing Home Licensing Orders - Project Numbers H5499011C, H5499012C, H5499013C, H5499014C

Dear Administrator:

The above facility was surveyed on February 10, 2019 through February 26, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5499011C, H5499012C, H5499013C, H5499014C that were found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On February 10 and 26, 2019, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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

Electronically Signed — 03/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00073	A. BUILDING: ______ B. WING ______	C 02/26/2019

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CALEDONIA REHABILITATION & RETIREMENT	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

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2 000	Continued From page 1 The following complaints was/were found to be substantiated: H5499012C. Correction orders issued at 4658.0520 Subp. 1 0830 H5499013C. Correction orders issued at 4658.0520 Subp. 1 0830 H5499011C. Correction orders issued at 4658.0520 Subp. 1 0830, 4658.1530 Subp. C 1545 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor,	2 830	Completed.	3/27/19

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2 830	Continued From page 2	2 830		

and identify signs and symptoms of dehydration for 1 of 3 residents (R3), who displayed signs and symptoms of a gastrointestinal illness and was admitted to the hospital for dehydration. The facility's failure resulted in actual harm to R3 when the resident required hospitalization for dehydration.

Findings include:

R3's hospital discharge summary dated 1/25/19, indicated R3 was admitted to the hospital on 1/22/19. The summary included the reason for hospital admission was hypernatremia and dehydration. Hospital course indicated prior to admission R3 had suffered nausea, vomiting and diarrhea and was found to be hypernatremic in the emergency room where he was treated with intravenous fluids.

R3's facility Admission record included dementia without behavioral disturbance, gastro-esophageal reflux disease, and dysphagia.

R3's annual Minimum Data Set (MDS) dated 12/16/18, indicated R3 had severe cognitive impairment. The MDS also indicated R3 was occasionally incontinent of bowel and was not on a diuretic medication.
R3's nutrition care plan dated 7/31/18, included alteration in nutrition/hydration with the associated goal will consume 1600 milliliters (ml) of fluid per day (6 cups). Interventions included administer medications as ordered, observe effects on food intake.

R3's historical physician orders included: offer 4 ounces of water or sugar free beverage three times per day with a start date of 10/30/18, and stop date of 1/29/19.

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2 830	Continued From page 3 Physician orders did not indicate R3 was on a fluid restriction and/or scheduled laxatives. R3's bowel movement record from 1/1/19 through 1/22/19, indicated R3's was continent of bowel and had formed stools one episode of incontinence with watery/loose stool on 1/4/19. The record indicated R14 had a change in bowel pattern that began on 1/14/19: -On 1/14/19, at 1:00 p.m. R3 was incontinent of large loose/water stool and was incontinent and at 1:34 p.m. had another incontinent episode of medium loose/watery stool. -On 1/15/19, at 3:05 a.m. R3 was incontinent of large putty like stool and at 10:00 a.m. was incontinent of medium loose/water stool -On 1/16/19, at 12:52 p.m. R3 was incontinent of medium loose/watery stool, and at 8:04 p.m. was continent of large loose/water stool. -On 1/17/19, at 12:58 p.m. R3 was incontinent of large loose/watery stool, at 8:46 p.m. was continent of medium loose/water stool. -On 1/18/19, at 1:09 p.m. R3 was incontinent of medium loose/watery stool -On 1/19/19, at 1:37 p.m. R3 was incontinent of large loose/watery stool, and at 8:06 p.m. was continent of small loose/water stool. -On 1/20/19, at 1:43 p.m. R3 was continent of large loose/watery stool. -On 1/21/19, at 1:25 p.m. R3 was incontinent large loose/watery stool, at 9:41 p.m. was continent of small formed normal stool. R3's vital sign record indicated although R3 had several loose stools (blood pressure, heart rate, and temperature) were not monitored during the time R3 demonstrated signs and symptoms of illness. Prior to R3's last recorded vital signs were documented on 1/7/19.	2 830		

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2 830	Continued From page 4	2 830		

R3's January Medication Administration Record (MAR) reflected the physician order to offer 4 ounces of water three times a day. The MAR included boxes that were either coded that R3 did not receive the water or an amount. Based on the documentation from the fluid intake record it could not be ascertained if the fluid documented on the MAR was combined with the totals from the fluid intake record.
R3's documented fluid intake record reviewed from 1/14/19, through 1/21/19 included
-1/14/19, total intake 720 ml -MAR indicated no additional fluid.
-1/15/19, total intake 720 ml -MAR included 120 ml
-1/16/19, total intake 530 ml -MAR included 100 ml
-1/17/19, total intake 580 ml -MAR included 120 ml
-1/18/19, total intake 600 ml -MAR indicated no additional fluid
-1/19/19, total intake 720 ml -MAR indicated no additional fluid
-1/20/19, total intake 600 ml -MAR indicated no additional fluid
-1/21/19, total intake 240 ml -MAR indicated no additional fluid

R3's fluid intake record was reviewed from 1/14/19, through 1/22/19; the record lacked evidence R3's fluid balance was evaluated for fluid balance and/or lacked evidence R3 was assessed and monitored for dehydration. The record further lacked evidence fluids were encouraged and/or increased to maintain hydration.

R3's progress note dated 1/21/19, at 1:36 a.m. indicated R3 had several loose foul smelling bowel movements since Thursday night 1/17/19,

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2 830	Continued From page 5	2 830		

three emesis on the shift. R3 had been in bed all shift in discomfort and no appetite. The note indicated standing orders with Mylanta and clear liquid diet. Called on call doctor to obtain a stool sample.

R3's progress note dated 1/21/19, at 4:04 p.m. indicated R3 had not had any loose stools and temperature was 97.8. A subsequent progress note at 4:30 p.m. indicated R3 felt better and abdomen was not hurting, and would continue to monitor stool.

R3's physician note dated 1/22/19, indicated reason for special visit was because R3 had nausea, vomiting, and diarrhea for three days. The note included, "started with nausea vomiting and diarrhea on Friday, 1/18 into Saturday 1/19. Several loose stools initially and have since slowed down. He continued vomiting into Monday morning 1/21. Oral intake has been minimal, even for him eating snacks and minimal liquid intake. No vomiting or diarrhea today but is noted to appear more tired than normal." Physician notes indicated that vital taken today (1/22/19) R3 had low grade temp of 99.6, elevated pulse to 130's, oral fluids offered but he only took sips. The physician included diagnosis of dehydration and plan was to send to the emergency room.

R3's progress note dated 1/22/18, at 3:15 p.m. indicated R3 was admitted to the hospital for hypernatremia and dehydration.

During an interview on 2/10/19, at 12:22 p.m. licensed practical nurse (LPN)-A indicated there was an gastrointestinal illness a few weeks ago that effected several residents. LPN-A confirmed R3 was admitted to the hospital for dehydration. LPN-A reviewed and confirmed the R3 record

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2 830	Continued From page 6	2 830		

lacked monitoring of vital signs and for signs and symptoms of dehydration. Anna stated the physician should have been contacted.

During an interview on 2/10/19, at 3:22 p.m. director of nursing (DON) confirmed there was a gastrointestinal outbreak in the facility a few weeks ago and R3 had been admitted to the hospital for dehydration. DON reviewed R3's record and confirmed the lack of monitoring during acute period of illness. DON indicated that the physician should have been notified sooner than 1//22/19.

During an interview on 2/10/19, at 6:33 p.m. physician assistant (PA)-A indicated the facility had a norovirus outbreak which started on 1/18/19, providers were not notified until 1/22/19. PA indicated on 1/22/19, she reviewed R3's record and found R3's record lacked documentation of monitoring of vital signs and signs and symptoms of dehydration. PA-A stated when a nurse obtained vital signs he was tachycardiac with his heart rate in 130's, which was above R3's baseline. PA-A indicated she had R3 transferred to the hospital where he was found to be hypernatremic with sodium level of 155, and was dehydrated. PA-A stated the nurses should have identified R3 had a change in condition, notify the provider, and have monitored vital signs and symptoms of dehydration.

Facility policy Change in Resident's Condition or Status dated 1/2019, included: Our facility will promptly notify the resident his or her attending physician and representative of changes in the resident's medical/mental condition and/or status.
1. The nurse will notify the resident's attending physician or physician on call when there has been a) accident or incident involving the

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2 830	Continued From page 7 resident. b) discovery of injuries of an unknown source. d) significant change in the resident's physical/emotional/mental condition. e) need to alter the resident's medical treatment significantly. i) specific instruction to notify the physician of changes in the resident's condition. 3. Prior to notifying the physician or healthcare provider the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact change of condition tool. 5. Except in medical emergencies notifications will be made within twenty-four hours of a change in the resident's medical/mental condition or status. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system and/or policies and procedures according to the standards of nursing practice for monitoring and documenting for acute changes in condition for timely notification of the change in condition to the physician. The DON/designee could then provide education to licensed nursing staff of the expectations of performing routine assessments/evaluations in order to identify acute changes in condition. The DON/designee could develop an medical record auditing system to ensure evaluations/assessments are completed according to the standards of nursing practice as part of the facility's quality assurance program. In addition, The DON/designee could identify all residents in the facility that require mechanical lift transfers, perform comprehensive safe transfer assessments for mechanical lifts. The DON/designee could then review and/or revise resident care plans to ensure accuracy	2 830		

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2 830	Continued From page 8 based on the lift assessment. The DON/designee could then provide education and competency testing to direct care staff, then develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		3/27/19

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21545	Continued From page 9 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to have a system for accurately transcribing physican orders into the electronic health record (EHR) to prevent and/or reduce the risk for medication errors for 2 of 2 (R8, R2) records reviewed with transcription errors with the potential to effect all 39 residents residing at the facility. Findings include: R8's Admission Record dated 2/10/19, indicated R8 was admitted to the facility on 12/26/18, with diagnoses that included diabetes type II. R8's hospital discharge summary dated 12/26/19, included the following orders: -Lantus (long acting insulin) 5 units; inject under the skin at bedtime -Melatonin (sleep medication) 5 mg by mouth at bedtime.	21545	Completed.	

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R8's physician orders transcribed into the electronic health record (EHR) upon admission to the facility on 12/26/18, did not reflect the order for Lantus and the order for Melatonin was transcribed as "Melatonin give on tablet by mouth at bedtime" and did not include a dose to be administered.

R8's physician visit note dated, 1/8/19, included, R8 was a diabetic type 2. In review of discharge paperwork it was noted he was to be on Aspart (short acting insulin) 12 units at bedtime. Transcription error lead him not to receive long acting Lantus since admission (12/26/18. The note included: No increased thirst or hunger, No infection. Per nursing order, he has had finger stick blood sugars completed three times daily, averaging 115-192. Goal blood sugars readings should be 120-160 due to age. The note further included the order to "Re-introduce lower dose of Lantus 2 units daily due to lower glycemic readings at skilled nursing facility"

R8's hand written physician order dated 1/8/19, included the order for Lantus 2 units daily and clarification for Melatonin 5 mg at bedtime.

R8's December and January medication administration record (MAR)'s indicated R8 was not administered Lantus from 12/26/18 through 1/8/19; 14 missed doses. The MAR's also indicated R8 was administered Melatonin however, between 12/26/19 and 1/8/19, there was no indication what dose of Melatonin was administered.

R2's Admission Record dated 2/10/19, included diagnosis of diabetes type 2.

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21545	Continued From page 11 R2's physician visit dated 1/31/19, included: start Lantus long acting insulin, at bedtime with monitoring finger stick blood sugar twice daily at variable times. At this moment R2 is receptive to this plan. R2's handwritten physician orders dated 1/31/19, included Lantus 2 units subcutaneous at bedtime for diagnosis of diabetes type 2 R2's current physician orders provided during the survey included Lantus solution Pen-Injector 100 units/milliliter; inject 2 units subcutaneously at bedtime (start date 1/31/19.) R2's January and February's medication administration record (MAR) did not reflect the order for insulin. However, January and February's treatment administration record (TAR) included the insulin order. The TAR indicated from 1/31 through 2/4/19, Lantus was not administered and 5 doses were missed. R2's record lacked evidence of a reason why the doses were omitted. During an interview with licensed practical nurse (LPN)-A confirmed R2 had missed doses of insulin because the order was transcribed as a treatment and not a medication. LPN-A indicated when orders were received from the physician via verbal, faxed, or written the nurse would transcribe the order into the EHR system and fax the order to pharmacy. LPN-A indicated the progress note would be written that there was a new order, and the order was placed in the paper chart. For verbal orders, the physician would then sign the order during the next visit. LPN-A stated for a new admission or readmission orders were entered into the que and a second nurse would	21545		

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21545	Continued From page 12	21545		

check the orders, verify, and release the orders from the cue. LPN-A stated routine orders aside from admission/readmission were not transcribed into the que, and/or verified by a second nurse for accuracy. LPN-A stated there was not always two nurses working in order to review and verify transcribed orders.

During an interview on 2/10/19, at 1:10 p.m. director of nursing (DON) indicated a few weeks ago physician assistant (PA)-A brought medication transcription errors to her attention. DON stated orders were missing or not transcribed from the admission/readmission orders. DON indicated since that time, admission/readmission orders were transcribed in the record by one nurse, placed in the que, then another nurse would review, verify, and make the orders active. DON stated there was not a verification system in place for routine orders not associated with admission/readmissions.

During an interview on 2/10/19, at 6:33 p.m. physician assistant (PA)-A stated even though she had brought concerns with medication transcription issues, the problem still seemed to be ongoing. PA-A stated the facility did not have a system in place for checking transcribed orders. PA-A indicated one of the transcribed issues had to do with insulin; it was transcribed onto the treatment administration record, instead of the medication administration record, and since it was entered as a treatment, the insulin was missed.

During an interview on 2/26/19, at 11:53 a.m. consultant pharmacist (CP)-A stated PA-A had contacted him regarding transcription issues that were occurring at the facility. CP-A stated the suggestion was to avoid verbal orders and that

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the facility fax the original handwritten prescription to the pharmacy to ensure the order was correctly dispensed. CP-A indicated even if the facility received a fax prescription and the facility faxed it to the pharmacy, the pharmacy could not control how staff entered it into the residents electronic health record. If the order was entered wrong, however, the prescription was filled correctly, could still result in a medication error. CP-A stated the pharmacist would review monthly physician orders with hand written orders/faxes to ensure the electronic record matched. If the order started off as a verbal order, and if the physician was there on a weekly basis, the order would be wrong for a week if the facility did not have an order verification system in place at the time the ordered was transcribed into the medical record. CP-A stated it was an expectation orders were double checked by nursing.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement a system for a verification system for physicians orders that are transcribed in the electronic health record to ensure accuracy. The DON/designee could then provide education to licensed nursing staff on the system. The DON/designee could then develop and implement an auditing system to ensure ongoing compliance as part of the facility's quality assurance program.

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