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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3Q31

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER - WELLS**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2009**

6. DATE OF SURVEY **7/31/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Kathy Hahn, HFE NE II 12/12/2018 (L19)

18. SURVEYOR SIGNATURE Date:
Kamala Fiske-Downing, Enforcement Specialist 12/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

August 7, 2018

Mr. Steve Fritzke, Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

RE: Project Number S5436027

Dear Mr. Fritzke:

On June 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 31, 2018, the Minnesota Department of Health and on July 30, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on June 7, 2018. The deficiencies not corrected are as follows:

E0036 -- S/S: F -- 483.73(d) -- Ep Training And Testing
F0803 -- S/S: B -- 483.60(c)(1)-(7) -- Menus Meet Resident Needs/prep In Adv/followed

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

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

- State Monitoring effective August 12, 2018. (42 CFR 488.422)

As we notified you in our letter of June 23, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from

September 7, 2018.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 7, 2018. (42 CFR 488.417 (b))

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: Fax:

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2018

Revised Letter

Mr. Steve Fritzke, Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

RE: Project Number S5436027

This is a revised letter. The S/S for the federal deficiences has been changed from an "F" to a "C".

Dear Mr. Fritzke:

On June 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 31, 2018, the Minnesota Department of Health and on July 30, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2018. Based on our visit, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, effective July 20, 2018. The deficiencies not corrected are as follows:

E0036 -- S/S: C -- 483.73(d) -- Ep Training And Testing
F0803 -- S/S: B -- 483.60(c)(1)-(7) -- Menus Meet Resident Nds/prep In Adv/followed

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Since these deficiencies are considered to be in substantial compliance, remedies outlined in our letter to you dated June 23, 2018 will not be imposed.

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

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:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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

cc: Licensing and Certification File

Electronically delivered

CMS Certification Number (CCN): 245436

November 8, 2018

Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

Dear Administrator:

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

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

Effective July 20, 2018 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	R 07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER - WELLS	**55 TENTH STREET SOUTHEAST WELLS, MN 56097**

(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
{E 000}	Initial Comments An on-site post certification revisit (PCR) for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 7/30/18 and 7/31/18, 2018. The facility remained NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	{E 000}		
{E 036} SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	{E 036}		8/27/18

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

Electronically Signed | 08/13/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	R 07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER - WELLS	**55 TENTH STREET SOUTHEAST WELLS, MN 56097**

(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
{E 036}	Continued From page 1 preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures and communication plan. This had the potential to affect all 41 residents currently residing in the facility. Findings include: The facility's Emergency Preparedness Plan dated 7/17/18, included a policy and procedure for training and testing based on the facility's risk assessment. Although, there was a policy in place to conduct an exercise based on the risk assessment, the facility had not implemented training for new or existing staff, persons who were providing services under arrangement, or volunteers. Interview with the administrator on 7/30/18, at 2:00 p.m., confirmed the facility had not operationalized a training plan for emergency procedures and had not yet conducted a table top or full scale exercise.	{E 036}	The facility will implement training for new and existing staff, community EMS staff and volunteers based on risk assessment policy for the facility. The facility will conduct a table top exercise instructing staff, both new and existing , as well as the volunteers and community EMS staff, of procedures to follow in the event of an emergency. Following the completion of the table top exercise, an all staff meeting of the facility will be conducted so all Parkview staff are informed of emergency procedures in the event of an actual emergency. Yearly training, testing and orientation of the program will occur. The facilities Maintenance Director and Administrator are responsible for implementation, oversight, monitoring and evaluation of the program.	
{F 000}	INITIAL COMMENTS	{F 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	Continued From page 2 An on-site post certification revisit (PCR) was completed on 7/30/18 and 7/31/18. The certification tags that were corrected can be found on the CMS 2567B. Also a tag had not been found corrected at the time of the onsite PCR. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 803} SS=B	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	{F 803}		8/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER - WELLS	**55 TENTH STREET SOUTHEAST WELLS, MN 56097**

(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 803}	Continued From page 3 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure food items given to residents receiving a pureed diet were on the daily menus and served as written to the resident population. This had the potential to affect 6 of 6 residents (R11, R15, R17, R27, R29, R30) residing in the facility, who received a modified pureed diet. Findings include: The facility weekly menus and audits from 7/17/18 to 7/30/18, were reviewed. The dinner menu posted on 7/19/18, included creamy coleslaw. Review of the meal audit dated 7/19/18, indicated carrots were served in place of coleslaw for residents who received pureed foods. Review of the dinner menu posted on 7/28/18, included spring greens with orange. Review of the meal audit dated 7/28/18, indicated pickled beets were served in place of the spring greens for residents who received pureed foods. The menu's had not been updated to reflect the alternate food changes for residents who received pureed food. Record reviews for R11, R15, R17, R27, R29, R30 revealed current orders for a pureed diet.	{F 803}	Any necessary menu item substitutions will be posted on the menu board prior to meal service. Dietary staff will receive instructions from Dietary Manager on posting menu item changes/substitutions. The Director of Dietary is responsible for oversight, monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	R 07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER - WELLS	**55 TENTH STREET SOUTHEAST WELLS, MN 56097**

(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 803}	Continued From page 4 Interview with the dietary director (DD) on 7/30/18, at 11:45 a.m., verified the above alternate food items that were served to the pureed residents on 7/19/18 and 7/28/18, were not updated on the menu to reflect the changes. The DD further included she was unaware the menus needed to be updated when changes in food items occurred. Interview with dietary cook (DC)-A on 7/31/18, at 9:24 a.m., indicated he was not aware menus needed to be updated when alternate food item were served to residents. DC-A further included he had been re-educated on how to puree foods and to track when an alternate food item was given, but was not instructed to update the menus with the changes.	{F 803}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3Q31

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER - WELLS**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2009**

6. DATE OF SURVEY **06/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Reduction in the number of certified SNF/NF beds from 50 beds to 45 beds, effective September 1, 2018, in accordance with a change in licensure. Due to five beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective September 1, 2018, all 45 facility beds are certified SNF/NF. They currently have five (5) on layaway.

17. SURVEYOR SIGNATURE Date:
Jennifer Kolsrud, HFE NE II 07/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/19/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7015 0640 0003 5695 2902

June 23, 2018

Mr. Steve Fritzke, Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

RE: Project Numbers S5436027 and H5436006

Dear Mr. Fritzke:

On June 7, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. In addition, at the time of the June 7, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5436006 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 17, 2018 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 7, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and

Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER - WELLS	**55 TENTH STREET SOUTHEAST WELLS, MN 56097**

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted June 4, 5, 6 & 7, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop an emergency	E 001 7/2/18 JPN	The facility will develop a facility-based and community risk assessment, utilizing	7/17/18

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

Electronically Signed | 07/01/2018

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E 001	Continued From page 1 preparedness (EP) plan that included all required components specified within the condition, including a comprehensive approach to meet the health, safety and security needs of the staff and client population during an emergency or disaster situation. This had the potential to affect 41 current residents residing in the facility. The cumulative effect of the systemic problem resulted in the provider's inability to ensure the provision of quality health care in a safe environment. Findings Include: The facility failed to utilize an all hazards approach to establish an EP training and testing program. E029: The facility failed to develop and implement an EP plan that comprehensively addressed their communication plan. E036: The facility failed to develop and maintain an EP plan for training and testing based on their emergency plan and risk assessment.	E 001	an all-hazards approach. The facility will develop strategies to manage natural disasters, power failures and other emergencies that would affect the facilities ability to provide care and services to the residents. The facility will develop an emergency preparedness plan that addresses a facility communication plan to all involved with the facility. The facility will develop an emergency preparedness plan that addresses appropriate training and testing as it relates to the facility and community risk assessment. The Facilities Maintenance Director and Administrator will oversee and implement the all-hazards risk assessment facility wide.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility's written emergency communication plan failed to contain a description of how the facility	E 029	The facility will develop an emergency preparedness communication plan to be reviewed and updated annually.	7/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 029	Continued From page 2 will coordinate patient care within the facility, across healthcare providers, and with state and local public health departments in order to protect the health and safety of their patients/ residents. This has the potential to affect the 41 current residents. The findings include: The facility's Emergency Preparedness Plan dated November, 2017, failed to address all required components for communication. The facility failed to indicate what alternate means of communication are available during an emergency: Names and contact information, emergency official contact information, primary/alternate means of communication, methods for sharing information to ensure continuity of care, method for sharing information on occupancy/needs, and method of sharing information with residents/families.	E 029	The communication plan will encompass how the facility will coordinate resident care within the facility during an emergency. The communication plan will include: a) names and contact information b) emergency officials contact information c) primary and/or alternate communication means during an emergency d) methods or a plan to share information to ensure continuity of care e) a method or plan to share occupancy/needs and f) a method or plan to share and get updated information to residents and families. Responsible staff: to implement the communication plan of the overall emergency plan will be the 1) Facilities Maintenance Director and 2) Administrator.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing	E 036		7/17/18

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E 036	Continued From page 3 program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program based on the emergency plan, risk assessment, policies and procedures and an appropriate communication plan. This had the potential to affect all 41 residents currently residing in the facility. Findings include: The facility's Emergency Preparedness Plan dated November, 2017, included policies and procedures for various emergency concerns,	E 036	The facility will develop and maintain an emergency preparedness " training and testing" program ties into the risk assessment protocol developed. This training and testing will be reviewed annually and appropriate updates made. Policies and procedures for specific emergency concerns as: a) chemical spills b) bio-terrorism c) active shooter d) tornados e) blizzards will be based on the facilities risk assessment. Training will be provided for all existing as well as new staff ,	

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E 036	Continued From page 4 such as, chemical spill, bio-terrorism and active shooter. However, the plan was not based on the facility's risk assessment, and there was no evidence the facility had implemented training for new or existing staff, persons who were providing services under arrangement, or volunteers. During interview on 6/7/18 at 11:30 a.m., with the Administrator, director of nursing (DON) and maintenance director regarding the facility's emergency plan. The Administrator and DON verified they had not yet implemented any training for staff.	E 036	vendors, contracted employees or volunteers. Training will be implemented by facility staff and qualified professionals an a regular basis to ensure compliance with the training and testing program. The Facilities Maintenance Director and Administrator will be responsible to oversee, provide appropriate training to staff, vendors, contracted vendors and volunteers to assure compliance.	
F 000	INITIAL COMMENTS A recertification survey was conducted June 4, 5, 6, & 7, 2018, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint H5436006 was completed and was found to be unsubstantiated. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		7/17/18

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F 550	Continued From page 5 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 6 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to treat 1 of 1 resident (R11) with dignity when an incontinent product were visible in a public area. Also failed to remove resident from commode in a timely maner for 1 of 1 resident (R9) who was left on commode for long period of time. Findings include: R11 was observed on 6/5/18, at 9:06 a.m. to be in her room sitting in her wheelchair with a visible plastic incontinent chuck pad (a pad used to absorb urine) placed underneath her on the cushion of the wheelchair. R11 was observed on 6/5/18, at 2:16 p.m. to be in her wheelchair being wheeled down to Mass. The plastic incontinent chuck pad was visible in the wheelchair. R11 was observed on 6/6/18, at 10:55 p.m. by nursing assistant NA-B and surveyor to be sitting in her wheelchair facing the window, with the chuck pad visible from the doorway of her room. NA-B tucked the chuck pad underneath R11 in the wheelchair and verified the chuck pad had been visible from the doorway. R11 was observed on 6/7/18, at 7:43 a.m. in her room sitting in her wheelchair with the disposable chuck pad visible from the doorway. R11's annual Minimum Data Set (MDS) an assessment dated 3/7/18, revealed R11 had severely impaired cognition. R11 was totally	F 550	Resident R11 had the disposable chux removed immediately. Resident R9 is being toileted every 2 hours while awake and chart if refuses and PRN. This will eliminate the waiting time on her call lights with increased rounding. Weekly audits will be completed by the DON and MDS nurse on resident dignity. Call light times will be reviewed weekly by the DON and MDS nurse. To sustain compliance, the facility will have weekly audits on dignity & call light times. These results will be discussed at QA quarterly. Nursing Staff meeting was held on June 19, 2018 and education was provided to nursing staff on dignity and resident rights.	

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F 550	Continued From page 7	F 550		

dependent on staff for toileting. R11's admission record identified a diagnosis of vascular dementia without behavioral disturbance.

On 6/6/18, at 10:21 a.m. nursing assistant (NA)-A stated today we have the chuck pad in her wheelchair because of her bath. NA-A stated normally when staff lifted R11 into the wheelchair she will start going to the bathroom or start to have a bowel movement right away. NA-A stated I would rather have it (bowel movement) on the chuck instead of the floor. NA-A stated it depends on who is working if they leave the chuck in the wheelchair.

On 6/6/18, at 10:46 a.m. nursing assistant (NA)-B stated we put a chuck pad on the cushion of the wheelchair, because she has a tendency to explode when she had a bowel movement, there are times when it goes through everything, we do not need a trail on the floor. NA-B stated the chuck pad was used for R11's protection and dignity. NA-B stated I would not want anyone to know that was there. NA-B stated we have had to clean up the wheelchair in the past and that was when we started using the chuck pads in the wheelchair.

On 6/7/18, at 8:34 a.m. the director of nursing (DON) stated I think they do it (put a chuck pad in her wheelchair) just in case she has an accident because she has had loose stools. The DON stated she did not have loose stools enough to have a large disposable chuck in her wheelchair all of the time. The DON stated she felt it was a dignity issue to have a visible disposable chuck in her wheelchair. On 6/7/18, at 8:38 a.m. the DON verified through observation R11 was sitting in her wheelchair in the dining room having breakfast

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with other residents and her chuck pad was visible from the back of her wheelchair.

The Resident Rights: Know your responsibility policy undated policy included, "the right to be treated with respect and dignity.
R9's admission record indicated R9's active diagnoses of: cerebral ischemic attack (stroke), diabetes, anxiety and depression.

R9's Minimum Data Set (MDS) an assessment dated 3/14/18, revealed the brief interview for mental status (BIMS) score to be 15/15, indicating R9 was cognitively intact. The MDS further revealed that R9 required extensive assistance of one-person physical assistance for activities of daily living, for toileting.

R9's care plan indicated she requires 1 staff assist and EZ stand lift for toileting on toilet in bathroom. The care plan further indicated R9 urgency with urination.

On 6/4/18, at 6:34 p.m. during an interview, R9 was asked regarding if she feels the staff treat her in a dignified manner. R9 said she had to use the bathroom a few days back and could not go in the bathroom because another resident was in there and the staff brought in a commode to use. R9 said when she was done they did not come in and take her off right away and had to keep yelling to get off. R9 stated she had a sore butt and they (staff) do not get me off when they were supposed to.

On 6/6/18, at 9:56 a.m. reviewed call light times on the facility computer, verified R9 light was on 6/1/18 for 35.9 minutes. Further review of call light times from 3/6/18 to 6/6/18 identified R9's

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F 550	Continued From page 9 call light was on: Over 30 minutes 11 times. Over 40 minutes 2 times. Over 50 minutes 2 times. Over 60 minutes 1 time. On 6/6/18, at 3:03 p.m. interview with director of nursing she would expect residents be assisted within 6 minutes of the call light going on.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of a nebulizer medication (medication broken into mist form and inhaled through a mask) was safe for 1 of 1 resident (R15) observed to self-administer a nebulizer treatment during a random observation. Findings include: R15's Admission Record, dated 6/6/18, included diagnosis of altered mental status. During observation on 6/7/18, at 9:09 a.m., R15 was seated in a wheelchair in her room watching television. R15 had a nebulizer mask on her face and was receiving an inhalation treatment. There were no staff present in the room with R15. At 9:12 a.m., the mist of medication was absent and the nebulizer machine remained running with the	F 554	Resident R-15: a self administration of medication assessment was completed and reviewed by IDT team and it was determined she was safe to hold nebulizer mask on her own with nurse administering medications. All residents who would like to self administer medications will be assessed and IDT team will decide if they are safe to do so. DON and MDS nurse will review all residents that may self administer and ensure all assessments are complete and safe. To sustain compliance, all self administration assessments will be reviewed PRN and quarterly to ensure	7/17/18

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F 554	Continued From page 10 mask remaining in place. At 9:24 a.m., licensed practical nurse (LPN)-A entered R15's room and stopped the nebulizer treatment. At the time LPN-A stated, I am not sure if R15 has a self-administration assessment (for the nebulizer treatment). LPN-A confirmed she had left R15 alone during the nebulizer treatment. LPN-A stated R15 does not take the mask off during the treatment, which is why I left her alone during the treatment. R15's physician orders, dated 5/24/18, included an order for DuoNeb (Ipratropium-Albuterol, bronchodilators) solution 0.5-2.5 milligrams (mg)/3 milliliters (ml), inhale 3 ml four times a day. R15's medication administration record, dated for 6/18 identified R15 was receiving the medication as ordered. During interview on 6/7/18, at 10:47 a.m., the director of nursing (DON) stated R15 had no self-administration assessment for self-administering a nebulizer medication. DON stated I like the nurses to stay with the resident during administration of a nebulizer treatment. The facility Policy and Procedure for Administration and Handling of Medications, reviewed 1/18, indicated A resident may self-administer medications of the comprehensive resident assessment and the interdisciplinary care plan teams indicate this practice is safe. A written order for self-administration of medications shall be obtained from the attending physician. The patient care policy "Self-Administration of Drugs" will be followed. The facility policy, Self Administration of Drugs, dated revised 8/04, indicated if a resident	F 554	accurate administration and safety by DON and MDS nurse. DON to monitor and assure compliance.	

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F 554	Continued From page 11 requests to self-administer drugs, it is the responsibility of the interdisciplinary team to determine that it is safe for the resident to self-administer drugs before the resident may exercise that right. A self-administration of medication assessment will be completed initially when the resident requests to self-administer medications.	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to	F 565		7/17/18

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F 565	Continued From page 12 participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure concerns raised at the resident council meetings were documented and presented back to the council, for 13 of 13 resident (R14, R25, R22, R10, R40, R16, R3, R15, R5, R38, R19, R18, R33) who were present during the resident council meeting with survey team. Findings include: On 6/4/18, at 7:44 p.m. R19 gave permission to review the last three months of resident councils meeting minutes. The resident council meeting minutes were reviewed for the months of February 2018, March 2018 and April 2018. The meeting minutes revealed no concerns had been documented in the meeting minutes. On 6/5/18, at 1:30 p.m. a resident council meeting was held with R14, R25, R22, R10, R40, R16, R3, R15, R5, R38, R19, R18, R33 and two surveyors. When asked the following questions: Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? Does the Grievance Official respond to the resident or family group's concerns? If the facility does not	F 565	Residents will be offered a resident council meeting on the third Thursday of every month from 1:30 -2:30. The residents last resident council meeting was completed on Thursday, June 21st at 1:30. Residents will have their Council meeting in the Activity Room with the doors closed for privacy. The Social Services Designee will be the responsible party assisting the residents with the resident council meeting. Residents will be offered the choice to elect resident council officers and members. The Social Services Designee will work with the residents to facilitate the council meeting. Residents will have the opportunity to facilitate the meeting. The meeting will be called to order and meeting minutes will be reviewed and approved by the residents. The Social Services Designee will type up the minutes and will disburse meeting minutes to department heads. All concerns raised by the residents will be listed in the minutes. The Social Services Designee will follow up with department	

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F 565	Continued From page 13 respond to concerns, does the Grievance Official provide a rationale for the response? The residents responded no. The resident's shared they have had concerns with the taste of the food and call light response times and stated they had shared these concerns in resident council meetings in the past. The residents stated the facility did not follow-up on concerns shared during the resident council meetings. On 6/5/18, 3:10 p.m. the director of nursing (DON) stated the previous social worker would share any concerns the residents shared at the residents council meetings with the department heads for follow up after the meetings. On 6/5/18, 3:22 p.m. the director of nursing (DON) stated the facility did not have any documentation of the resident concerns or follow-up to resident concerns from the resident council meetings. The DON stated this is a system problem and we will need to work on this. On 6/6/18, at 11:55 a.m. social services (SS) stated the facility did not have any grievances documented from the resident council meetings. SS stated the facility did not have any grievances on file since 2015. The undated Grievance Procedure included, "Issues brought up at Resident Council will be referred to the appropriate department head by the social worker. If the grievance is not satisfactorily corrected within one week by the appropriate department head, then give written notice to the administrator about your concern. The administrator will seek to correct the problem if possible, and will review the grievance with you and all concerned within seven days."	F 565	heads to review what has been done to address resident concerns. The Social Services designee will share findings and progress that were followed up on. The Social Services Designee created a needs/concern form that will be kept in the Social Services office. The form will be given to the department head to document what has been done to correct the concern. The form will be signed and dated. Follow-up will be done by the Social Services Designee with the residents at their council meetings or when asked by residents. Social Services Designee will be responsible and oversee the "Resident Council Meetings".	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		7/17/18

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F 656	Continued From page 15 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the activity plan of care to provide one to one visits for 2 of 2 residents (R11, R27) reviewed for activities. In addition, failed to develop a preventive care plan for 1 of 3 residents (R16) reviewed for pressure ulcers. Findings include: LACK OF ASSESSED ACTIVITY NEEDS BEING MET: R11 was observed on 6/05/18, at 2:16 p.m. to be in her wheelchair being wheeled down to Mass. R11's annual Minimum Data Set (MDS) an assessment dated 3/7/18, revealed R11 had severely impaired cognition, was usually able to understand and was usually understood. R11's admission record identified a diagnosis of vascular dementia without behavioral disturbance. R11's care plan last revised 3/7/18, included goal, "Will maintain current activity level to provide mental/social stimulation when tolerable to her day. One on ones once to twice a week with resident. Targeted Activities: Church, music programs, games, resident council and massages." R11's activity participation was reviewed from 3/1/18 to 6/6/18. During the time period reviewed R11 only received a one to one visit on 3/19/18.	F 656	The facility's Activity Director and/or Activity Assistants will provide 1:1 activity for residents identified and will document in the EMR as completed or weekly. Interdisciplinary team will identify residents during admission/care plans/significant change who may need 1:1 activities. Activity Director will meet with Activity Assistants to communicate residents in need of 1:1's and schedule time for that to happen. Activity Director or designated Activity Assistant will document 1:1's in EMR. All Activity staff will review the needs of the residents, the basics of 1:1's and EMR entry to ensure all staff fully understand the importance of the residents needs. Activity Director or designated Activity Assistants will review 1:1's and EMR entries weekly for one month and subsequently monthly for a quarter. Responsible staff: Activities Director	

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PARKVIEW CARE CENTER - WELLS	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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On 6/7/18, at 10:56 a.m. the activity director (AD) verified R11's care plan indicated the activity department would complete one to one visits once to twice a week. The AD verified the activity documentation revealed the last documented one to one visit completed with R11 was on 3/19/18. The AD stated she was aware the one to one visits were not getting done with R11 and stated with the new system (electronic medical record), only having two staff members in the activity department, the 1:1's have been slacking in the last year.

The Formulating a Resident's Plan of Care & Care Plan Review undated policy included, "Each department head will have responsibility to see that their portion of the resident's plan is implemented."
R27 had been observed on 6/4/18, at 3:50 p.m. R27 lying in bed on her back noted to have a U-shaped pillow on, roommates television was on at the time. R27 had been in bed since entered the building at 1:45 pm.

R27's quarterly MDS dated 4/17/18, revealed that R27, had severely impaired cognition, was rarely or never understood. R27's admission record identified a diagnosis of unspecified dementia without behavioral disturbance.

R27's activity care plan revised on 4/23/18, included goal, "Resident will express satisfaction with activity involvement, one on ones once to twice a week when tolerated."

R27's activity participation was reviewed from 1/1/18, to 6/6/18,. During the time period reviewed R27 received only two, one to one visits,

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on 1/12/18, and 2/19/18, during this time period.

On 6/7/18, at 10:56 a.m. the activity director (AD) verified R27's care plan indicated the activity department would complete one to one visits once to twice a week. The AD verified the activity documentation revealed two, one to one visits on 1/12/18 and 2/19/18. The AD stated she was aware the one to one visits were not getting done with R27.

LACK OF PRESSURE ULCER/SKIN CARE PLAN:

R16's admission record indicate R16 admitted to facility on 7/15/16, with diagnosis of peripheral vascular disease, (PVD), is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.

Event Report dated 11/9/17, indicated that R16 had an open area to right ankle 0.2 x 2. 0.1 centimeters, slightly open on outer right ankle bone, floats on pillow but kicks out in sleep. SBAR (situation, background, assessment, recommendation) report sheet sent to physician and return to facility on 11/9/17, stated under assessment there was an open area out right ankle. Ulcer was cleansed with normal saline and Opsite applied, will change every 3 days and as needed, float on pillows.

R16 quarterly Minimum Date Set (MDS) an assessment dated 4/3/18, revealed that R16 is cognitively aware with a Brief Interview for mental status (BIMS) score of 15. Also identifies that R16 had a stage 2 pressure ulcer.

During an interview with R16 on 6/5/18, at 12:51

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F 656	Continued From page 18 p.m., at which time R16 stated the sore on right ankle came about six month ago. I primarily lay on right side, then will turn on to my back, when my hip starts hurting, Does not get help or reminders from staff to turn and reposition. Does not float ankle off bed surface to prevent pressure on ankle. R16 also said the sore only hurts when I bump it or put pressure on it. Review of care plan with date of late revision 4/9/18, noted no care plan had been developed for prevention of pressure ulcer even though R16 has had a history of developing pressure ulcers and is at risk for pressure ulcers in the future do to diagnosis of peripheral vascular disease and resident preference to lay on right side. During interview on 6/5/18, at 2:42 p.m., with registered nurse (RN)-A who said, "The area [ankle ulcer] is no longer open." Also verified that there is no care plan for skin regarding prevention for developing pressure ulcers or risk of pressure ulcers due to diagnosis of PVD and history of pressure ulcer. On 6/5/18, at 2:52 p.m. nursing assistant (NA)-G had verified that R27's Kardex, (care guide for NA's), had not included preventive measure regarding skin break down/ulcer post right ankle pressure ulcer healed. On, 6/7/18, at 8:53 a.m. director of nursing (DON) verified that there was no care plan developed for R27's assessed history of developing skin bread down/pressure ulcers. Also said that one needs to be developed for R27.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		7/17/18

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F 689	Continued From page 19 §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 record review, the facility failed to ensure 1 of 3 residents (R26), who was reviewed for smoking, was assessed for smoking safety. Finding include: R26's annual Minimum Data Set (MDS), an assessment dated 4/11/18, indicated no tobacco use and was cognitively intact. During interview with R26 on 6/4/18, at 2:45 p.m., when asked if he smoked, R26 stated I had one (a cigarette) four days ago. I do not have my own cigarettes, I bum one from other residents. I told another resident I have to quit smoking or I am going to be hooked. When asked if he had informed any staff person he smokes, R26 replied no, but some of them see me out the window, as I have to go outside to smoke. Review of R26's record identified a smoking assessment for R26 had not been completed and R26's care plan lacked to include information regarding smoking. During interview on 6/5/18, at 3:03 p.m., licensed practical nurse (LPN)-B (when asked if R26	F 689	Resident R26 was assessed for smoking safety and was deemed safe. He does not smoke and prefers to not smoke- he states "it was a one time thing". Any resident that choses to smoke will be assessed for safety immediately even if they are a casual smoker. All smokers will be reviewed for safety by DON and MDS nurse PRN and quarterly. To sustain compliance, assessments will be evaluated on a prn basis and quarterly by the DON and MDS nurse. DON to oversee and monitor.	

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F 689	Continued From page 20 smoked) stated no and I have never seen him smoke. Surveyor informed LPN-B that R26 had stated he had smoked a cigarette four days ago. LPN-B stated assessments for smoking were completed for residents who smoked only. During interview on 6/6/18, at 8:43 a.m., LPN-B stated I talked to R26 yesterday and he informed me he was smoking cigarettes. During interview on 6/6/18, at 12:36 p.m., LPN-B stated she had not completed a smoking assessment for R26, nor had she documented a progress note regarding being informed R26 was smoking. LPN-B stated R26 stated he was not going to smoke anymore, so I am curious if he is going to continue to smoke or not. I will make a progress note. During interview on 6/6/18, at 1:09 p.m., the director of nursing (DON) stated R26 did not smoke. DON stated one day when sitting here I saw another resident handing R26 a cigarette. I informed R26 we need to do an assessment on you if you are going to smoke. That was six months ago. The DON stated she would expect staff to do a smoking assessment on R26 and document in the progress notes immediately when informed a resident was smoking.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 693		7/17/18

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F 693	Continued From page 21 ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure placement of a gastrostomy tube (G-tube) was checked prior to administration of medication and fluid intake for 1 of 1 resident (R15) with a g-tube, who was observed during medication administration. Findings include: R15's quarterly Minimum Data Set (MDS) an assessment dated 3/28/18, indicated R15 had a feeding tube and R15 had moderate cognitive impairment. During observation of medication administration on 6/4/18, at 4:15 p.m., licensed practical nurse (LPN)-C applied gloves, drew up 25 cubic centimeters (CC) of water into a syringe and flushed R15 g-tube, drew up two crushed medications in water into the syringe and administered the medications by g-tube, drew up	F 693	Resident R15 will have all of her medications administered individually through the G tube. Her fluid administration will be documented with every medication pass and also placement of tube prior to feeding and med administration will occur. DON and MDS nurse will have return demonstration from nursing staff of verification of tube placement and medication administration and feeding administration. A Nursing meeting was held June 19th, 2018 with review of these procedures. To ensure compliance, the DON and MDS nurse will audit feeding tube education administration bi-weekly for one month, then quarterly and PRN.	

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F 693	Continued From page 22 60 cc water in syringe, flushed the g-tube, drew up another 40 cc water into syringe, flushed the g-tube and removed gloves. However, LPN-C lacked to check placement of the g-tube prior to administration of medications. During interview on 6/4/18, at 4:48 p.m., when asked regarding checking placement of the G-tube prior to administering medications, LPN-C stated I just check to see that the G-tube is not leaking by looking at the surrounding area (G-tube site). I check for residual after 8:00 p.m. R15's care plan, dated revision 4/5/18, indicated requires tube feeding related to swallowing problem secondary to diagnosis of dysphagia (difficulty swallowing). Approaches included the resident is dependent with tube feeding and water flushes. See medical doctor (MD) orders for current feeding orders. R15's physician orders, dated 5/24/18, included administer 100 cc water flush after all medications every shift and check for residual every eight hours, if greater than 50 cc hold feeding and call MD. R15's medication administration record (MAR) identified the same. R15's record lacked documentation for water flush being given prior to medication administration and water flushes being given with administration of the medications. According to the State Operations Manual (SOM), Appendix PP for Long Term Care Facilities, "Monitoring the feeding tube How to verify the tube is functioning before a feeding and before administering medications, which may include: checking gastric residual volume (GRV) May be appropriate when initiating tube feedings or for	F 693	DON is responsible to assure compliance.	

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F 693	Continued From page 23 individuals who are unable to report symptoms such as bloating, nausea and abdominal pain. Care of feeding tube Defining the frequency of and volume used for flushing, including flushing for medication administration, and when a prescriber's order does not specify." During interview on 6/6/18, at 12:54 p.m., the director of nursing (DON) stated staff should check R15's g-tube for residual before feedings and before medication administration. DON stated staff were to give each medication individually with water flush between each medication. DON reviewed R15's record and confirmed water flush of 100 cc after medication administration was the only water being recorded for medication administration. DON stated we are going to have to include the water flushes before meds and when the medications are being given. The facility policy, Enteral Tube Medication Administration, dated revised 2/22/13, indicated Procedure: f. Enteral tubes are flushed before administering medications and after all medications have been administered with at least 30 milliliters (ml) of warm water. g. Each medication should be administered separately, flush with 15 ml of water between each medication. The dietician and primary doctor should be informed to make necessary decisions based on amount of total fluid intake.	F 693		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		7/17/18

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F 725	Continued From page 24 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure there were enough staff available for 3 of 40 residents (R9, R18, R10) interviewed who did not receive the assistance they needed, or felt the assistance was often not timely. In addition, based on interview and document review the facility failed to ensure staffing concerns raised at the resident council meetings were documented and presented back to the council for 2 of 2 resident (R18 and R10) present during the resident council meeting with survey team.	F 725	Residents R9, R10 and R18 will have increased rounding times of every 2 hours and PRN to reduce call light times. Call lights will be audited on a weekly basis by the DON and MDS Nurse and PRN. All call light times will be monitored on a weekly basis by the DON and MDS nurse and PRN. A meeting was held on June 19th with staff to discuss length of call light responses/times. Weekly call light review - times and staff trending will be tracked and education	

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F 725	Continued From page 25 Finding included: R9 had been interviewed on 6/4/18, at 6:41 p.m. R9 stated she has to wait for staff when she has to go to the bathroom. R9 stated she has had an accident and went in her pants one time. R9 said she felt stupid about having an accident and felt the staff did not give a "darn." R9's Progress notes reviewed as follows: 1. On 4/7/18, at 10:11 a.m. Behavior Note Note: resident loud, yelling, demanding to go to bathroom less than 1 hour after she just went, staff tried to redirect her and explain that others needed to be fed and toileted and that she had just gotten off, resident kept hollering. 2. On 4/28/18, at 10:12 p.m. Behavior Note Note Text: Resident yelling out for staff multiple times this shift. Wanting to be helped as soon as her light was on, multiple lights on along with hers. Resident worried about who was coming in to work. 3. On 5/7/18, at 3:02 p.m. Nurse's Note Note Text: Resident yelling loudly even when questions answered. "Help" "Help." Was assisted to the bathroom. Did urinate. Was talked to and asked about her day. Tried to calm but difficult. Is now in EZ chair. On 6/6/18, at 9:14 a.m. interview with nursing assistant (NA)-A verified R9 calls out when the call light is not answered right away. On 6/6/18, at 9:56 a.m. Director of nursing (DON) and surveyor reviewed call light response times found in the computer. The call light response time was from 3/6/18 to 6/6/18. The	F 725	provided. If needed, discipline will be initiated by the DON and MDS nurse to ensure prompt call light response times. To ensure compliance, the DON and MDS nurse will monitor call light times weekly and PRN as well as audits completed. Call light audits will be discussed at quarterly QA meetings. DON and MDS nurse to oversee call light responsiveness and compliance.	

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following information was found:
11 times more than 30 minutes
2 times more than 40 minutes
2 times more than 55 minutes
1 time more than 60 minutes.

On 6/6/18, at 10:15 a.m. NA-E stated R9 uses her call light a lot. Staff try to accommodate her the best they can but R9 wants to go (to the bathroom) as soon as the call light goes on.

On 6/6/18, at 2:58 p.m. interview with DON who said call light mostly are on around meal time and she has moved staff around to assist with answering them. DON stated there is no audits and no documentation of the call light times. DON stated her expectation would be to have call lights answered with in 6 minutes of resident turning it on and would expect the staff not turn it off. DON expectation would be to give verbal assurance to the residents that a staff member will be right in if the staff can not assist right away.

On 6/7/18, at 8:35 a.m. NA-F said in general, the staff try to answer the call lights within 5 minutes and will leave the light on incase someone is freed up first. NA-F stated R9 is very impatient and will call out when the call light is not answer right away. NA-F verified staff are aware of R9 request to have assistance right away. NA-F was asked regarding if cares are being met. NA-F became emotional and had tears in her eyes and said sometimes we are busy and she said she feels the cares are given and met but not in a timely manner.

On 6/07/18, at 10:57 a.m. administrator verified no facility assessment was completed which could have identified the lengthy call light wait

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times.
FACILITY FAILED TO FOLLOW UP ON STAFFING GRIEVANCES FROM RESIDENT COUNCIL MEETINGS:

R18 and R10 were interviewed on 6/5/18, at 1:30 p.m. a resident council meeting was held with thirteen residents and two surveyors. When asked the following questions: Do you get the help and care you need without waiting a long time? Does staff respond to your call light timely? R18 and R10 shared they have had concerns with call light response times and stated they had shared these concerns in resident council meetings. R18 stated we put our call light on and have to wait so long. R18 reported having to wait over thirty minutes for assistance and R10 agreed with R18. The residents stated the facility did not follow-up on concerns shared during the resident council meetings.

On 6/7/18, at 9:34 a.m. R18 and R10 were interviewed. R18 stated most of the time when she put her call light on it takes thirty minutes or more for it to be answered and R10 agreed. R10 stated I wonder what they (staff) are doing down at the station, because I can hear them talking and laughing and they just do not come to help. R18 stated having her call light on when she had to go to the bathroom made her feel anxious and worried she might not make it to the bathroom in time. R18 stated if I go to the door and motion for staff to come, I get a response and it is usually faster than the call light. R18 and R10 stated they have reported the concerns with call light response to the nurse and in resident council meetings. R10 sometimes I do not say anything (to staff) as nothing was done about their concerns anyway. R18 and R10 both stated they

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F 725	Continued From page 28 have reported their concerns with call lights being answered timely, but have not seen improvements in call light response. A call light audit report was reviewed from 3/1/18 to 6/5/18 and revealed there were seven times the call light was on for greater than thirty minutes in the room shared by R18 and R10 as follows: 3/8/18: call light was on for 34.7 minutes. 3/11/18: call light was on for 34.7 minutes. 4/3/18: call light was on for 35.2 minutes. 4/6/18: call light was on for 44.9 minutes. 4/9/18: call light was on for 55.4 minutes. 4/13/18: call light was on for 33 minutes 4/24/18: call light was on for 32.8 minutes. On 6/5/18, 3:10 p.m. the director of nursing (DON) stated the old social worker would share any concerns the residents shared at the residents council meetings with the department heads for follow up after the meetings. On 6/5/18, 3:22 p.m. the director of nursing (DON) stated the facility did not have any documentation of the resident concerns or follow-up to resident concerns from the resident council meetings. The DON stated this is a system problem and we will need to work on this. On 6/6/18, at 11:55 a.m. social services (SS) stated the facility did not have any grievances documented from the resident council meetings. SS stated the facility did not have any grievances on file since 2015.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		7/17/18

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F 755	Continued From page 29 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 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 ensure medications were available to be administered as prescribed by the physician, for 1 of 1 resident (R1) who was prescribed a fentanyl patch. Findings Include:	F 755	R1 was seen by the Nurse Practitioner and pain was re-evaluated with another medication initiated. All medications charted as not available will be assessed by the DON and MD notified in a timely manner. A medication	

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F 755	Continued From page 30 R1's Admission Record identified R1 was admitted to the facility on 8/17/16, with diagnoses of paraplegia and unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. R1's physician orders included fentanyl patch 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. R1's progress notes and medication administration record revealed the following missed fentanyl patch applications: 5/11/18, Orders Administration Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. No duragesic patch available. 5/14/18, Orders Administration Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. No supply. 5/17/18, Orders Administration Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. No supply. 5/20/18 Orders- Administrative Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified	F 755	error report will be completed for missed applications. All medications that are not available due to insurance or any circumstance will be addressed promptly and the MD notified for directive. To sustain compliance, the DON and MDS nurse will monitor medication administration weekly and PRN. DON and MDS nurse to oversee.	

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injury to unspecified level of lumbar spinal cord, subsequent encounter. No med.

5/23/18 Orders- Administrative Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. NO SUPPLY.

5/26/18 Orders- Administrative Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. No supply.

5/29/18 Orders- Administrative Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. None.

6/4/18 Orders- Administrative Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. No medication available.

6/1/18 Orders- Administrative Note: 72 hours 50/MCG/HR, apply 1 patch transdermal at bedtime every 3 day(s) related to unspecified injury to unspecified level of lumbar spinal cord, subsequent encounter. No patch.

6/5/18 Support Documentation: Note Text: Discussed the non-use of fentanyl patch as not available related to ins [insurance] coverage. Spoke with [facility nurse practitioner] and we will d.c. [discontinue] at this time and continue with Tylenol at Will re-eval [evaluate] PRN [as

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needed].

R1's medication error reports were requested for the missed applications of the fentanyl patch and revealed medication error reports had not been completed for the missed applications.

On 6/6/18, at 2:16 p.m. the director of nursing (DON) stated we called the pharmacy to have them send a supply (of fentanyl patches) and they stated not without insurance coverage. The DON explained R1 had let his medical assistance lapse, and declined to let the facility assist him with having his medical assistance reinstated. The DON verified R1 had orders for the fentanyl patch to be applied every three days. The DON stated the fentanyl patch was not applied six times per the physician's order. The DON verified the order to discontinue the fentanyl patch was completed on 6/5/18. The DON verified no medication error reports had been made for the missed fentanyl patch applications. The DON stated R1 was offered to purchase the medication and he refused and stated in my mind he could get it and the missed applications were not medication errors. The DON stated she felt he had enough money to purchase the patches as he had money to buy cigarettes.

The Administration and Handling of Medication Policy reviewed 1/18 included, "All medications shall be administered as ordered by the physician. Any medication errors should be reported to the Director of Nursing. The nurse making the error shall report all significant medication errors to the physician. "Significant medication error" means one which causes the resident discomfort or jeopardizes his or her health and safety. An explanation of the error

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F 755	Continued From page 33 shall be recorded in the resident's record. When a medication error is made, the nurse making the error is to complete a medication error report form and submit to the Director of Nursing."	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify specific mood symptoms for 2 of 5 residents (R15 and R40), who received anti-depressant medication, failed to identify specific target behaviors for 1 of 5 residents (R40), who received an anti-psychotic medication and failed to document clinical	F 757	Resident R15 and R40 - their care plans were reviewed and target behaviors were added to the care plans. Care plans will be reviewed for all residents on psychotropic medications to match target behaviors listed on	7/17/18

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F 757	Continued From page 34 justification for use of an antidepressant and antipsychotic medication for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include: LACK OF RESIDENT SPECIFIC MOOD SYMPTOMS: R15's quarterly Minimum Data Set (MDS) an assessment, dated 3/28/18, included diagnosis of depression, mild depression and moderate cognitive impairment. During observation on 6/6/18, at 9:30 a.m., R15 was seated in wheelchair in her room watching television. At 3:18 p.m., R15 was in the facility activity room watching a television show with other resident's. R15's current physician orders, included an order for Lexapro (antidepressant) 10 milligrams (mg) every day. R15's medication administration record, dated for 6/18, identified R15 was receiving the medication as ordered. R15's Consent for Use of Psychotropic Medication, dated 4/25/18, indicated target behaviors were isolation, sadness and crying. R15's current care plan, included depression related to major depressive disorder. Approaches included, needs time to talk when exhibiting sadness. Encourage the resident to express feelings. The resident's activities of choice are often musical events. The resident needs to be reminded/escorted/encouraged to attend. Uses antidepressant medication related to depression. Approaches included, administer antidepressant medications as ordered by physician.	F 757	assessment by the DON and MDS nurse. Care plans will be audited monthly by the DON and MDS nurse and PRN to ensure target behaviors are being monitored and documented. To sustain compliance, audits will be completed monthly by the DON and MDS nurse and reviewed at quarterly QA Meetings. DON and MDS nurse to oversee.	

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Monitor/document side effects and effectiveness every shift. Dose reduction reviewed at least every 6 months. Consent for medication use reviewed and signed annually. Pharmacy consultant review done as per protocol.

The care plan lacked to include R15's mood symptoms of isolation, sadness and crying.

During interview on 6/7/18, at 9:14 a.m., nursing assistant (NA)-D (when asked what mood symptoms for depression were for R15), stated R15 always seems to be happy. I have never been told what mood symptoms to watch for her.

During interview on 6/7/18, at 10:49 a.m., the director of nursing (DON) stated R15 mood symptoms are not on R15' care plan. They are probably on my assessment (Consent for Use of Psychotropic Medication). DON stated the target behaviors were not carried over to the care plan.

R40's quarterly Minimum Data Set (MDS) an assessment, dated 5/8/18, included diagnoses of Alzheimer's disease, depression, mild depression, severe cognitive impairment, behaviors of physical and verbal and an admission date of 11/10/17.

LACK OF CLINICAL JUSTIFICATION FOR STARTING ANTIDEPRESSANT:

During observation on 6/5/18, at 8:52 a.m., an unidentified nursing assistant (NA) was assisting R40 with dressing. R40 was yelling at the NA. R40 was seated in her wheelchair with upper body completely dressed and lower body needing pants, socks and shoes. R40 was moving her wheelchair about the room. NA waited for R40 to

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accept assistance to finish dressing.

R40's current physician orders, included orders for Citalopram (antidepressant) 10 mg at bedtime, Seroquel (antipsychotic) 25 mg one time a day and Seroquel 50 mg at bedtime. R40's medication administration record, dated for 6/18, identified R40 was receiving the medication as ordered.

R40's record identified an SBAR (Situation, Background, Assessment, Recommendation) Report dated 11/29/17, identified the problem is combative, agitated, hitting out at staff, attempts to redirect not successful times two weeks. Only medications are Aricept and Namenda. Do we still need these? Can you review and maybe start something for behaviors or we may need to look for higher dementia care facility and an order was written with to start Seroquel 50 mg at bedtime and 25 mg in the a.m. A Referral Form dated 12/14/17, identified an order was written to start Citalopram 10 mg every day.

R40's current care plan included, psychotropic drug use, at risk for adverse consequences related to receiving antipsychotic medication for diagnoses of Alzheimer's disease and dementia with behavioral disturbance. Approaches included administer medications as ordered, assess effectiveness of drug treatment, monitor and report side effects, dose reduction reviewed at least every six months, pharmacy consult review monthly. Behavioral symptoms, resident resists care. Approaches included allow resident to have control over situations, if possible. Maintain a calm environment and approach to the resident. Offer one-step verbal directions for tasks. Allow extra time to process the information. The

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resident uses psychotropic medications related to disease process: Alzheimer's disease and dementia. Approaches included administer psychotropic medications as ordered by physician. Monitor for side effects every shift. Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate at least every six months. Consent for medication use reviewed and signed annually. Moses monitoring done quarterly. Orthostatic hypotension monitoring as per policy. Monitor/record occurrence of for target behavior symptoms: refusal of cares, agitation and document per facility protocol.

R40's care plan lacked specific mood symptoms for the use of the Citalopram and resident specific symptoms of agitation.

Review of R40's physician progress notes dated 12/14/17, 1/25/18, 3/15/18, and 5/24/18, lacked documented clinical rational for initiating and the continued use of the Seroquel and Citalopram.

During interview on 6/7/19, at 10:59 a.m., the DON stated specific symptoms for agitation was not identified in R40's record. DON stated refusal of cares was not a reason to give antipsychotic medication. DON stated R40's record had no specific mood symptoms for the use of the Citalopram. DON stated the Citalopram was started because we were trying to get rid of the Seroquel. We stopped the a.m. dose of Seroquel and added the Citalopram to see if it would help. DON confirmed there was no documented physician clinical rationale for initiating and the continued use of the Seroquel and Citalopram.

A policy for antidepressant and antipsychotic

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F 757	Continued From page 38 medication use was requested, but not provided.	F 757		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to be free from medication error rate of five percent or greater identified during observations of 33 medications with 5 errors for residents (R27, R34, R244 and R15) which resulted in an error rate of 15 percent. Findings include: R27's current physician orders included an order for Miralax Powder (laxative) 17 grams one time a day. R27's medication administration record (MAR) identified the medication was being given as ordered. During observation on 6/6/18, at 11:52 a.m. licensed practical nurse (LPN)-A mixed Miralax 17 grams into a glass of water. LPN-A administered one swallow of Miralax to R27. R27 started to make the sound of clearing her throat. LPN-A stated when R27 starts to make that noise she is disagreeing with something. LPN-A made no further attempt to give R27 the rest of the Miralax. During interview on 6/6/18, at 12:54 p.m., the director of nursing (DON) stated I would expect	F 759	Resident R27 was re-approached with Miralax and will be given more than one opportunity to take medication prior to charting refusal. Resident R34 will be administered will be administered one tablespoon of Metamucil. Resident R244, a ascorbic acid order was corrected in the MAR to match the current medication in the cart and MD order. Resident R15's medications are being administered individually through the g tube. Medication pass will be audited on a weekly basis by DON and MDS nurse. A staff meeting with nurses was held 6/19/18 and all nursing staff reviewed medication safety. All policies and procedures were reviewed and DON and MDS nurse will conduct weekly audits to ensure accurate medication administration. Audits will be completed weekly and reviewed and discussed at quarterly QA meetings.	7/17/18

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F 759	Continued From page 39 the nurse to go back to R27 and try again (in regards to offering only one swallow of the Miralax). R34's MAR, dated for the month of 6/18, identified R34 was receiving Metamucil powder (laxative) one tablespoon in the morning. (R34's current physician orders were requested, but not provided). During observation on 6/6/18, at 8:59 a.m., LPN-B stated R34 received one heaping teaspoon of Metamucil. LPN-B placed one heaping teaspoon of Metamucil into a glass of water. R34 was observed to drink the glass of Metamucil. At 11:01 a.m., LPN-B reviewed R34's current physician orders and the label on the bottle of the Metamucil and stated R34 was to receive one tablespoon of Metamucil. During interview on 6/6/18, at 12:54 p.m., the DON stated giving one heaping teaspoon of Metamucil instead of one tablespoon as ordered was a medication error. R244's current physician orders included an order for Asorbic Acid (vitamin) one tablet one time a day. R244's MAR identified the same. The physician orders lacked to identify the strength of Asorbic Acid to be given. During observation on 6/6/18, at 9:17 a.m., LPN-B placed 1000 milligrams (mg) (according to the medication label) of Asorbic Acid into a medication cup and administered the medication to R244. During interview on 6/6/18, at 12:54 p.m., (in regards to the strength of Asorbic Acid R244 was	F 759	DON and MDS nurse to oversee.	

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to receive was not identified on R244's current physician orders), the DON stated that was a clarification on 6/4/18 that the pharmacy sent back, which did not get put into the computer system right away. DON showed surveyor a Medication List for R244 the facility had received on 6/4/18, which identified Asorbic Acid take 1,000 mg daily. DON stated when the order is put into the computer system the MAR is automatically updated with the information. DON reviewed R244's orders and confirmed the strength had not been transcribed into the facility computer system. When asked who was responsible for updating the orders in the computer system when a change of order is received, the DON stated during the day I would be responsible and other times the nurse on the floor would be responsible.

R15's current physician orders, included an orders for Isosorbide Dinitrate (nitrate) 10 mg via PEG Tube three times a day, Metoprolol Tartrate 50 mg vie PEG tube two times a day and administer 100 cubic centimeters (CC) water flush after all medications every shift. R15's MAR identified the same.

During observation on 6/4/18, at 4:15 p.m., LPN-C crushed one tablet of Isosorbide Dinitrate 10 mg and one tablet Metoprolol 50 mg together, placed the crushed medications into a plastic medication cup and mixed the medications with water. LPN-C applied gloves, drew up 25 cc of water into a syringe and flushed R15 G-tube, drew up the two crushed medications in water into the syringe and administered the medications by G-tube, drew up 60 cc water in syringe, flushed the g-tube, drew up another 40 cc water into syringe, flushed the g-tube and removed

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F 759	Continued From page 41 gloves. According to the State Operations Manual (SOM), Appendix PP for Long Term Care Facilities, "The standard of practice is that crushed medications should not be combined and given all at once via feeding tube. Flushing the feeding tube between each medication is also standard of practice." During interview on 6/4/18, at 4:48 p.m., when asked regarding water flushes during medication administration stated LPN-C stated R15 had orders for 100 cc water flush after all medications only. When asked what the facility policy was in regards to giving medications together via G-tube, LPN-C stated I would have to ask the DON. At 6:47 p.m., LPN-C stated it was the facility policy to give medications together. During interview on 6/6/18, at 12:54 p.m., the DON stated staff were to give each medication individually with water flush between each medication. The facility policy, Enteral Tube Medication Administration, dated revised 2/22/13, indicated Procedure: f. Enteral tubes are flushed before administering medications and after all medications have been administered with at least 30 milliliters (ml) of warm water. g. Each medication should be administered separately, flush with 15 ml of water between each medication. The facility Policy and Procedure for Administration and Handling of Medications dated reviewed 1/18, indicated Medication Errors: all medications shall be administered exactly as ordered by the physician.	F 759		

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F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food items given to residents receiving a pureed diet were on the daily menus and served as written to the resident population. This had potential to affect 6 of 6 residents (R11, R17, R15, R27, R29, R30) receiving a modified puree diet residing in the facility who were identified to consume meals.	F 803	Residents on modified pureed diets will receive pureed food items on the menu for that meal. All residents will receive food items on the menu for that day or lighter fare items of their choice in the proper texture according to their diet order.	7/17/18

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F 803	Continued From page 43 Findings include: A provided Weekly Menu undated identified as Week 1, identified a weeks' period of posted meals. The menu identified a dinner (evening) meal for Monday, which was listed as Chowmein casserole, oriental veg. Egg roll, fruit cobble or lighter fare choice (alternate menu BLT, entrée salad, sliced beef sandwich, or soup of the day). Nowhere does it indicate a different menu for pureed diets. During observation of the evening meal service on 6/4/18, 4:55 p.m., dietary cook (CK)-A began dishing up plates for R11, R17, R15, R27, R29, R30, with 6 plates of pureed foods, the food served was beef stroganoff, mashes potatoes, and squash. The rest of residents received either the main entree stated on the menu or a choice for the lighter fare choices. During observation of the lunch meal service on 6/5/18, 12:15 p.m., it was noted that R11, R17, R15, R27, R29, R30 received pureed Chowmein casserole, and puree fruit cobble which was yesterdays menu meal. The posted menu for 6/5/18 was chicken macaroni salad, copper pennies, fresh fruit. Record reviews for R11, R17, R15, R27, R29, R30 reveal current orders for a pureed diet. During an interview on 6/5/18, at 11:03 a.m., CK-B in regards to R11, R17, R15, R27, R29, R30 receiving a different meal as posted on the menu. CK-B said, "The process is that we will puree the leftovers from the day before or meal before, up to three days whatever is left over is used." At this time, observed CK-A pureeing	F 803	Dietary staff will receive in/servicing by the CDM on proper practices for meal service for residents with texture modified diets by 7/17/2018. Meal service will be monitored and recorded a minimum of 5 days a week 2-3 meals per day by Dietary Director/CDM through 8/17/2018. Dietary Director will continue to monitor meal service after 8/17/2018 to insure all residents are receiving food items per written menu and diet at all times. Person responsible: Dietary Director to assure corrective action and compliance by 7/17/2018.	

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F 803	Continued From page 44 dessert for lunch for the puree diets. CK-A confirmed that she was pureeing, peach cobbler leftover from supper on 6/4/18, along with some leftover fruit cocktail. During an interview 6/7/18, at 09:36 a.m. CK-C said, "We will use the leftovers from the day before or from the last three days that are in the refrigerator. If there is mashed potatoes or squash on the regular menu then they (pureed diets) will get that with a different protein." On 6/7/18, at 11:19 a.m., per phone interview with corporate register dietitian, (RD), stated that she was not aware that the facility was using leftovers for the pureed diets. In addition, she would expect that whatever is served should be the posted menu foods for the meal. RD also stated, "That pureed diets should get what everyone else is being served." A facility policy on menu service and food preparation was not provided.	F 803		
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	F 838		7/17/18

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F 838	Continued From page 45 address or include: §483.70(e)(1) The facility's resident population, 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	F 838		

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F 838	Continued From page 46 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing 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 and record review, the facility failed to complete a comprehensive assessment of the facility needs to ensure an effective plan was in place to maintain the highest practicable care for all 40 residents residing at the facility. Findings include: When interviewed on 6/7/18, at 10:57 a.m. the administrator stated he started his employment at the facility three weeks ago, and that a facility assessment of the facility needs had not been completed as required. The copy of a facility assessment given to the team, was only a shell and and needed to be completed. No further information was provided.	F 838	Point of Clarification: The Administrator of Record, at the time of this survey, had only been employed at the Facility as Administrator of record since 5/21/18 which is 2 weeks not 3 weeks. The facility will complete the facility wide assessment to comply with 483.70(e)(1), 483.70(e)(2) and 483.70(e)(3). The facility will complete a comprehensive assessment of facility needs to assure an effective and meaningful plan be in place to provide care and services to the 40 residents residing at the facility. The Administrator will oversee, develop and implement, complete and review and evaluate the plan with Department Managers to assure compliance.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865		7/17/18

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F 865	Continued From page 47 promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a Quality Assurance and Performance Improvement (QAPI) plan assuring care and services are identified to maintain at acceptable levels of performance and continually improved. This had the potential to affect all 40 residents residing in the facility. Findings include: When interviewed on 6/7/18, at 12:27 p.m. the administrator indicated there was no current QAPI plan in place to assure the care and services are maintained. The administrator indicated their systems that are to be in place are lacking, similar to the facility assessment and emergency preparedness are currently being worked on to complete. No further information was provided.	F 865	The facility will develop and implement a QAPI plan to assure compliance with 483.75(a), 483.75(a)(2), 483.75(h)and 483.75(l). The facility will form a QAPI staff committee including the Medical Director to develop the QAPI plan assuring care and services are identified and reviewed in order to maintain standards of care identified. Review of the plan is on-going and areas of improvement are made and monitored accordingly. In order to sustain compliance, the QAPI committee will meet monthly with a set agenda for review of goals and areas for improvement. The DON and Administrator will oversee and coordinate the efforts of the QAPI committee including the development of the QAPI plan.	

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F 867	Continued From page 48	F 867		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a Quality Assurance and Performance Improvement (QAPI) plan to correct and identify quality deficiencies with identified areas of infection control and environment maintenance. This had the potential to affect all 40 residents residing in the facility. Finding included: On 6/7/18, at 12:27 p.m. the administrator stated when he started three weeks ago he identified a lack of communication between the previous owners and staff. He stated he was told to get ready for the upcoming survey and is currently working on building relationships with the staff. At 12:37 p.m., the director of nursing stated there was a meeting initially to discuss last year's survey results and they met on a quarterly basis for Quality Assurance the facility had no documentation, policies, procedures or action plans in place to prevent repeat deficiencies in the area of infection control and environmental maintenance. A policy was requested and none received.	F 867	Point of Clarification: The Administrator of Record started duties as Administrator or record starting 5/21/18 which is 2 weeks not 3. The facilities QAPI committee will develop a plan to comply with 483.75(g) and 483.75(g)2. The facility will develop and implement a QAPI plan to correct deficiencies in identified areas of infection control and environmental maintenance. The goal will be for positive and desirable outcomes for the residents in the facility. To ensure compliance, The QAPI committee will meet monthly and review the plan directed at infection control and environmental maintenance. The committee will assure appropriate documentation, development of policies and procedures will be created & to prevent and avoid repeat deficient practices. The Administrator , DON and Facilities Maintenance Director will be responsible	7/17/18

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F 867	Continued From page 49	F 867	to assure the plan is carried out.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		7/17/18

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F 880	Continued From page 50 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program, which included comprehensive surveillance of resident infections that did not require an antibiotic to identify and analyze possible patterns of infection in the facility, including signs/symptoms of infections to prevent the spread of communicable disease and	F 880	The facility will develop and establish an Infection Control Program and Control program to comply with 483.80 (a)(1)(2)(4)(e)(f). The Infection Control Policy and Log was reviewed and revised to include the day to day tracking of signs and symptoms of	

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F 880	Continued From page 51 infections for 1 of 1 resident (R21) identified to have had an infection that was not treated with an antibiotic. This had the potential to affect all residents in the facility. The facility failed to implement a program to prevent Legionella (a bacterium) in the facility water systems to prevent cases and outbreak of Legionnaires' disease (a serious type of pneumonia). This deficient practice had the potential to affect all 40 residents who resided in the facility, staff and visitors. In addition, based on observation, interview and document review the facility failed to ensure the tip of an eye bottle medication did not touch the upper eye lids during administration; failed to ensure handwashing before and after medication administration procedures for 1 of 9 residents (R15) observed during medication administration and failed to ensure handwashing/glove use for a blood sugar check, cleansing of a glucometer and injection of an insulin medication for 1 of 1 resident (R7) observed during for a blood sugar check. Findings include: Review of the monthly infection control tracking and trending from 4/2017 through 6/6/2018, revealed the facility had no documentation that they had analyzed data or identified trends to determine corrective action to prevent the spread of the infections that did not require the use of an antibiotic. The facility was unable to provide any further logs or tracking tools for infections that did not require the use of an antibiotic in the facility and was unable to provide documentation that they had tracked infections that did not require the use of an antibiotics from 4/2017 through 6/6/2018.	F 880	infections not requiring antibiotics. Staff meeting was held and policies and procedures were reviewed and discussed. R21 was treated with an antibiotic. The facility is developing a water management program which will include reducing the risk and spread of Legionella/Legionnaire's disease. The Facilities Maintenance director and Administrator will develop. The DON or the MDS nurse will review the Infection Control Logs weekly to ensure proper tracking is being conducted on a day to day basis. Audits will be conducted weekly and PRN to ensure proper handwashing and glove hygiene. The incidents involving the glucometer, blood sugar check and injection of an insulin medication taking gloves off and not re-washing will be audited and monitored to assure compliance by the DON and MDS nurse weekly as identified above. Day to day monitoring will be recorded into the infection control log by the DON and MDS nurse and reviewed on a weekly basis. To sustain compliance, audits will be completed and the DON or MDS nurse will report finding for discussion and review at the quarterly QA Meeting. DON, MDS nurse, Facilities Maintenance Director and Administrator to oversee the entire Infection Control program for the	

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F 880	Continued From page 52 R21's progress note dated 1/25/18 included, "Resident's T-101 [temperature] after receiving Tylenol and [an] hour prior. Resident sleeping soundly. Attempted to waken resident to give her a drink and resident was unable to close her mouth to take a drink or follow direction from writer. Resident's morning medications were held due to not being awake and previous emesis. Resident staying in bed this shift and to remain comfortable. Son notified of resident's condition and wishes to be notified of changes. They were planning a visit but changed their mind due to her illness." R21's progress note dated 1/25/18 included, "Seen by [physician-A] on rounds. Reviewed medication, tx [treatments] and vital signs. Will get influenza swab - no other changes at this time." R21's progress noted dated 1/25/18 included, "Started Tamifly [Tamiflu] 75 mg [milligrams] BID [twice a day] x [times] 5 days. Family notified." R21's influenza swab lab results dated 1/25/18 was negative. R21's infection was not listed on the monthly infection control tracking and trending for the month of 1/2018. On 6/6/18, at 9:59 a.m. the director of nursing (DON) stated she only tracked and trended infections in her infection control book that required an antibiotic. The DON stated she did track other infections (that did not require an antibiotic) and stated she had that information in her head as they are a small facility. The DON	F 880	facility.	

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	245436	A. BUILDING _____ B. WING _____	C 06/07/2018

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F 880	Continued From page 53	F 880		

verified there was no tracking, trending or analysis of infections that did not require an antibiotic that was documented.

The Infection Control policy dated 1/10/17, included, "1. Ongoing infection surveillance is done. Infections are mapped and reported to the Quality Assurance Committee on a quarterly basis."

LACK OF IMPLEMENTING LEGIONELLA INFECTIONS PREVENTION PROGRAM:

During an interview on 6/6/18, at 9:09 a.m. with the director of nursing (DON). The DON was asked if the facility had developed policies and procedures to reduce the risk of growth and spread of Legionella (Legionella bacteria are microscopic organisms that live in soil and water and are the most common cause of Legionnaires' disease) and other opportunistic pathogens in building water systems. The DON answered, "I am not going to waste your time. We have done nothing for Legionella."

The DON confirmed the facility had not conducted/documented a facility risk assessment to identify where waterborne pathogens could grow and spread in the water system.

The DON confirmed the facility had not implemented a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.

The DON confirmed the facility had not specified

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F 880	Continued From page 54 testing protocols and acceptable ranges for control measures, and documented the results of testing and corrective actions taken when control limits were not maintained. LACK OF HAND HYGIENE DURING EYE MEDICATION ADMINISTRATION: R15 had been observed on 6/4/18, at 4:15 p.m., licensed practical nurse (LPN)-C was observed to enter R15's room, apply gloves, administered Systane (eye lubricating medication) one drop to each eye. During the procedure, the tip of the eye drop bottle touched both of R15's upper eyelids and LPN-C lacked to wash hands prior to the administration of the eye drops. LPN-C removed gloves, applied gloves and administered two medications by g-tube to R15. LPN-C removed gloves, placed a nebulizer medication into nebulizer cup, placed the nebulizer mask onto R15 and started the nebulizer machine. LPN-C waited for the medication to finish, rinsed the nebulizer equipment, washed hands and walked out of R15's room. LPN-C failed to wash hands between procedures. R7 had been observed on 6/4/18 at 4:25 p.m. when LPN-C proceeded to gather equipment, entered R7's room, applied gloves, checked R7's blood sugar, carried the glucometer out to the medication cart, removed gloves and cleansed the glucometer using a Cavi (disinfectant wipe). LPN-C lacked to wash hands after checking R7's blood sugar, lacked to wear gloves to clean the glucometer and lacked to wash hands after cleansing the glucometer. LPN-C then applied gloves, drew up eight units of Humalog insulin into a syringe, walked back into R7's room, injected the medication into R7's abdomen, removed gloves, disposed of the syringe into a	F 880		

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F 880	Continued From page 55 sharps container on the medication cart and signed for medications. LPN-C lacked to wash hands. During interview on 6/4/18, at 4:48 p.m., LPN-C confirmed the above. LPN-C stated the glucometer was a shared glucometer for all residents. During interview on 6/6/18, a t 12:54 p.m., the director of nursing (DON) stated hands should be washed prior to procedures and after procedures. DON stated every time gloves are removed staff were to wash hands. DON stated she would expect the eye bottle tip not to touch the eyelids. DON stated she would expect staff to wash hands after a blood sugar check, gloves should be worn when cleansing the glucometer and hands were to be washed after cleansing the glucometer. The facility policy infection control, revised 1/17, indicated Purpose: To protect the residents and staff from risk of acquired infection. E. Handwashing 5. Handwashing is required after removing and disposing of gloves. 4. a) Gloves are worn for 2) handling items or surfaces soiled with blood or body fluids. The facility policy Blood Glucose Monitoring, revised 1/18, indicated ll. Policy: C. Universal precautions must be followed and appropriate personal protective equipment used. i.e. gloves. The facility policy Insulin Administration, dated 1/18, indicated lll. Procedure: A.1. Wash hands.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		7/17/18

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F 921	Continued From page 56 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine maintenance of facility doors and doorframes which included 2 of 30 rooms (Rooms 2 and 4) reviewed for environment. Findings include: During the review of the environment on 6/4/18, at 3:30 p.m. the following areas were noted to have multiple areas of scraped off paint located on the lower and upper portion of the doors and/or door frames inside the rooms and bathrooms: Room 2 and 4 with shared bathroom both had several chipped paint areas and rusty spots on door and trim. As well as the inside on the entrance doors and bathroom entrance door for room (2 and 4). Room 4 also had missing ceiling tile and noted a large tan water stain surrounding the missing tile. During a subsequent environmental tour on 6/7/18, at 12:23 p.m. the maintenance director verified the above findings. The maintenance director indicated the painting was completed of the outside doors in the halls but not in the resident's rooms. There was no painting schedule nor routine environmental rounding conducted. When asked regarding the general maintenance of the facility. The maintenance director was told not a priority from previous ownership. He added	F 921	The facility will put into place a "preventative maintenance program" which will include a painting schedule for rooms, doors and trim, windows, hallways and common areas. The preventative maintenance program will include all areas of the building including ceiling tiles, lighting and floor care. The Facilities Maintenance Director will review and follow the preventative program put into place to make sure the building and rooms are maintained properly. The preventative maintenance program and maintenance completed will be reviewed and discussed at the quarterly QA meetings. The Facilities Maintenance Director and Administrator will oversee the program.	

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F 921	Continued From page 57 the ceiling tiles in room 4 have been like that since started three years ago. Although a policy was requested, none was provided.	F 921		

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/07/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on June 07, 2018. At the time of this survey, Parkview Care Center Wells Inc. was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2018

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

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K 000	Continued From page 1	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us, and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Parkview Care Center Wells Inc. is a 1-story building. The original building was constructed in 1961 and was determined to be of Type II (222) construction. In 1967, an addition was constructed and determined to be of Type II(222) construction, with a partial basement. In 1999, an addition was constructed and was determined to be of Type II(000) construction. The building will be surveyed as one building Type II (000).

The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

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K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the HVAC was installed according to 9.2. The deficient practice could affect 41 residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 06/07/2018, the corridors in the 1961 and 1967 buildings are being utilized as the supply air plenum for the resident rooms. This deficient practice was verified by the Facility Maintenance Director.	K 521	The facility will request a waiver from the State to assure that we are not violating 9.2. Responsible: Facility Maintenance Director and Administrator will secure the appropriate waiver from the State Fire Marshals Office.	7/20/18