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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 72EI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245544**

2. STATE VENDOR OR MEDICAID NO. (L2) **699435200**

3. NAME AND ADDRESS OF FACILITY
(L3) **VICTORY HEALTH & REHABILITATION CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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) **11/12/2015**

6. DATE OF SURVEY **12/20/2018** (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) **12/31**

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

12. Total Facility Beds **87** (L18)

13. Total Certified Beds **87** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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:
Brenda Fischer, Unit Supervisor — 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 12/21/2018 (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 **01/01/1991** (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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/03/2018** (L33)

DETERMINATION APPROVAL

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

January 11, 2019

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

REVISED LETTER

RE: Project Numbers H5544071 AND H5544072

Dear Administrator:

On October 31, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 5, 2018. (42 CFR 488.422)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2018. (42 CFR 488.417 (b))

On November 7, 2018, we informed you that the following enforcement remedies were being recommended to the CMS Region V Office for imposition:

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

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on October 12, 2018 and a standard survey completed on October 19, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 14, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated standard survey, completed on October 12, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on October 12, 2018, as of December 5, 2018.

On December 20, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by a review of your plan of correction and on December 21, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to standard survey, completed on October 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as

of December 5, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 12, 2018, as of December 5, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 5, 2018.

In our letter of October 31, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 15, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies in their letter of October 31, 2018 and November 7, 2018:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2018 be rescinded as of December 5, 2018. (42 CFR 488.417 (b))

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us
Enclosure(s)

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 21, 2018

CMS Certification Number (CCN): 245544

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

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 December 5, 2018 the above facility is certified for:

87 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 87 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 72EI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245544**

2.STATE VENDOR OR MEDICAID NO.
(L2) **699435200**

3. NAME AND ADDRESS OF FACILITY
(L3) **VICTORY HEALTH & REHABILITATION CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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) **11/12/2015**

6. DATE OF SURVEY **12/20/2018** (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)
12/31

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

12.Total Facility Beds **87** (L18)

13.Total Certified Beds **87** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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:
Brenda Fischer, Unit Supervisor 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 12/21/2018 (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
01/01/1991
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/03/2018
(L33)

DETERMINATION APPROVAL

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

December 21, 2018

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Numbers H5544071 AND H5544072

Dear Administrator:

On October 31, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 5, 2018. (42 CFR 488.422)

• Discretionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2019. (42 CFR 488.417 (b))

On November 7, 2018, we informed you that the following enforcement remedies were being recommended to the CMS Region V Office for imposition:

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

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on October 12, 2018 and a standard survey completed on October 19, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 14, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated standard survey, completed on October 12, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 5, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on October 12, 2018, as of December 5, 2018.

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5, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 5, 2018.

In our letter of October 31, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 15, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies in their letter of October 31, 2018 and November 7, 2018:

- Discrentionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2018 be rescinded as of December 5, 2018. (42 CFR 488.417 (b))

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us
Enclosure(s)

cc: Licensing and Certification File

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

Electronically delivered December 21, 2018

CMS Certification Number (CCN): 245544

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
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Dear Administrator:

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Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
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DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 72EI

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(L3) **VICTORY HEALTH & REHABILITATION CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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) **11/12/2015**

6. DATE OF SURVEY **10/19/2018** (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
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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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:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
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___ 9. Beds/Room

* Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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:
Austin Fry, HFE NE II 11/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 11/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
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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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 7, 2018

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Numbers H5544071 and H5544072

Dear Administrator:

On October 12, 2018 an abbreviate standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 19, 2018, the Minnesota Departments of Health and Public Safety completed a standard survey to determine that 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. 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 evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the findings, the following remedies will remain in effect:

- State Monitoring effective November 5, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 31, 2018.

In addition, this Department recommended the enofrcement remedy listed below to the CMS Region V Office for imposition :

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of October 31, 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 December 31, 2018.

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

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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 for the abbreviated standard survey completed on October 12, 2018 should be directed to:

Daphne Ponds, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: daphne.ponds@state.mn.us
Phone: (651) 201-5185
Fax: (651) 281-9796

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 for the standard survey completed on October 19, 2018 should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

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.

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));

- 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 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 April 12, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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
	245544	A. BUILDING ______ B. WING ______	C 10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 A survey with Centers for Medicare and Medicaid (CMS) Appendix Z Emergency Preparedness Requirements was conducted on 10/15/18 to 10/19/18, during a recertification survey. The facility is found to be NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in	E 024		12/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/17/2018

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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E 024	Continued From page 1 an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures for using volunteers in their emergency preparedness plan (EPP). This had the potential to affect all 62 current residents residing in the facility. Findings include: The facility EPP, dated 11/17, was reviewed. The EPP lacked any policy or procedure regarding the use of volunteers during an emergency. On 10/19/18, at 10:42 a.m. the facility EPP was reviewed with the facility administrator. The administrator stated she did not see anything in the plan to address volunteers and the use of community people.	E 024	E024 Policies/Procedures Volunteers and Staffing o Policy has been developed to address requirements for E024 regarding the use of volunteers and staffing. o Executive director, plant operations director, director of nursing, and key emergency staff personnel educated on E024 policy. o Policy will be reviewed annually. o The Executive Director will report to QAPI on an annual basis as findings and updates of policy review for E024 are identified. o Compliance date 12/5/2018	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]	E 026		12/5/18

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E 026	Continued From page 2 (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included policies and procedures to address and identify the facility's role under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials during an emergency. This had the potential to affect all 62 residents currently residing in the facility. Findings include: The facility's EPP dated 11/17, was reviewed. The EPP lacked a policy or procedure for addressing the facility's role under an 1135 waiver declared by the Secretary during an emergency to provide services at an alternate site for their residents. During interview on 10/19/18, at 10:42 a.m. the EPP was reviewed with the administrator. She	E 026	E026 Roles Under a Waiver Declared by Secretary o Policy has been developed to address requirements for E026 regarding the roles under waiver declared by secretary. o Executive director, plant operations director, director of nursing, and key emergency staff personnel educated on E026 policy. o Policy will be reviewed annually o The Executive Director will report to QAPI on an annual basis as findings and updates of policy review for E026 are identified. o Compliance date 12/5/2018	

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E 026	Continued From page 3 stated she did not know of a specific policy or wording in the facility's plan that talked about what the facility would do, should there be a declaration to waive provider requirements.	E 026		
F 000	INITIAL COMMENTS On 10/15/18 to 10/19/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, the requirements for Long Term Care Facilities. In addition, at the time of the survey, an investigation of complaint H5544073 was completed. The complaint was substantiated with deficiencies cited at F921 and F925. 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 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.	F 554		12/5/18

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F 554	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess residents for the ability to self administer nebulizer treatments after nurse set up for 1 of 1 residents (R41) observed self administrating a nebulizer treatment. Findings include: R41's diagnoses as identified on the Admission Record with a print date of 10/17/18, included acute respiratory failure, asthma and history of cardiovascular disease (stroke). C41's quarterly Minimum Data Set (MDS) dated 8/29/18, indicated she was moderately, cognitively impaired. R41's Physician's orders dated 9/28/18, included Ipratropium-Albuterol (a combination bronchodilation medication, to make breathing easier) 0.5-3mg (milligrams) per 3 ml (milliliter) ampule. The order directed to nebulize (inhale via tube) 1 vial twice daily as needed. The physician's orders did not indicate R41 could self administer nebulizer medication. During observation on 10/16/18, at 10:10 a.m. R41 was lying in her bed in her room when trained medication assistant (TMA)-C entered the room to respond to the roommate's call light. R41 told TMA-C she wanted a "breathing treatment." TMA-A exited the room and at 10:14 a.m. returned with the medication for R41's which is delivered inhaled by a nebulizer, device used to administer medication in the form of a mist inhaled into the lungs. TMA-C donned a pair of gloves, opened the plastic medication vial and poured the medication (Ipratropium-Albuterol) into the nebulizer reservoir and then twisted the	F 554	F554 Resident Self-Administration of Medication o R41 has been comprehensively reassessed for self-administration of nebulizer medications. o All other resident's with nebulizer medication will be reviewed for appropriate self-administration. o Education will be provided to nurses on comprehensive assessments for self-administration of nebulizer medication. o Audit of the comprehensive assessments for self-administration of nebulizer medication will be done 2 times per week for 4 weeks and then monthly for 2 months. o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed o Compliance date. 12/5/2018	

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F 554	Continued From page 5	F 554		

top back on. At 10 :15 a.m., TMA-C turned on the nebulizer machine, located on R41's bedside table, and handed the mouthpiece of the nebulizer to R41. R41 held the tubing in her mouth and began to breathe in the medication. TMA-C then exited the room. Initially R41 continuously held the mouthpiece in her mouth, breathing normally as the nebulizer ran. At 10:17 a.m., R41 removed the mouthpiece from her lips and looked at it as the machine continued to run, then re-inserted the mouthpiece and took a more breaths. At 10:20 a.m. R41 placed the mouth piece on the bedside table, and the nebulizer machine continued to run, with a mist of medication distilling from the mouth piece. There was approximately one-third of the medication remained in the reservoir and was not inhaled. At 10:24 a.m. R41 reached over and turned the nebulizer machine off. R41 remained lying in her bed in her room, awake, the nebulizer shut off, and the reservoir still contained medication.

At 10:51 a.m. TMA-C, in the presence of the surveyor, reviewed the nebulizer and TMA-C acknowledge there was still medication in the reservoir.

A facility document, Self Administration of Medications, dated 9/12/17, indicated R41 wished to self administer "nebs after set up." The "Interdisciplinary Team Assessment" section, listed six criteria to make a Yes/No determination for self administration of medication, among which included: "Does the resident have the fine motor control to enable safe self-administration?", "Upon observation, resident is able to self administer medication correctly?" and "Does the resident have the cognitive ability to accurately self-administer the requested medication?" The

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F 554	Continued From page 6	F 554		

assessment questions Yes/No and comment area on the form were left blank. The form did not identified if R41 was able to safely self administer her nebulizer treatments. The form was signed by a nurse, dated 9/12/17. Under one "quarterly Review section" there was another signature dated 12/11/17. Two additional "quarterly review" sections were both left blank.

R41's nursing progress notes from 5/1/18 to 10/17/18 were reviewed. The progress notes contained no entries regarding R41's ability to safely self administer nebulizer medications.

When interviewed on 10/16/18 at 10:51 a.m., TMA-C stated she did not complete any assessments with R41 before or after she got her "neb" medication. TMA-C stated R41 was able to say when she needed her nebulizer and R41 was able to administer the nebulizer on her own. TMA-C stated she "thought" R41 was assessed to be able to self administrate her nebulizer.

During interview on 10/16/18 at 4:22 p.m. licensed practical nurse (LPN)-C stated R41's nebulizer treatments were not scheduled, but given only as needed. LPN-C stated "it was obvious" R41 did not get the full dose, because there was medication in holder after looking at R41's neb on her bedside table, and added the holder should have been rinsed out and let dry. LPN-C stated she thought R41 could run the neb on her own, but if there was medication remaining, R41 "should have been monitored more closely" and they needed to reassess R41's ability to administer her own nebulizer treatments.

When interviewed on 10/17/18 at 12:21 p.m. registered nurse (RN)-A stated if a resident

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F 554	Continued From page 7 wanted to self administer medication, an assessment must be completed for each resident and each type of medication. RN-A stated R41 did not have a self administration assessment completed, and also should have had direct nurse supervision when R41 got her nebulizer. RN-A also stated it was out of a TMA's scope of practice to administer an as-needed nebulizer treatment, because a nurse needed to do some pre and post-medication assessments. When interviewed on 10/18/18 at 10:46 a.m. the director or nursing (DON) stated R41 was not cognitively able to self administer a neb treatment, and a nurse should be there at bedside to administer R41's treatments. A facility policy, Self Administration of Medications, revised November 2016, indicated an individual resident may self-administer medication of the resident requests and the interdisciplinary team has determined that self-administration is clinically appropriate. The policy further indicated if determined a resident could self administer medication, a physician's order was to be obtained for each medication a resident was qualified to self administer. The policy also directed nursing staff performs weekly/monthly checks of the resident's accuracy in self administration and notes this on medication treatment record or nurses notes.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		12/5/18

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F 580	Continued From page 8 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 9 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified timely of a change in condition for 1 of 1 residents (R64) closed record reviewed whom developed congestion with coarse lung sounds. Additionally, the facility failed to notify the phsyican of the return of 1 of 1 residents (R27) reviewed for mood and behavior who returned the to the facility after illicit drug use and an extended leave of absence against medical advice. Findings include: R64's quarterly Minimum Data Set (MDS) dated 7/24/18, identified R64 had severe cognitive impairment and required extensive assistance with her activities of daily living (ADLs). Further, R64 had medical diagnoses including dementia and peripheral vascular disease (PVD; disease causing narrowed blood vessels), however, R64 was not considered to have a life-limiting prognosis. R64's signed Provider Orders for Life Sustaining Treatment (POLST) dated 3/27/13, identified R64 was a DNR (Do Not Resuscitate) and on comfort focused care. However, a section labeled, "Interventions and Treatment," directed "All antibiotics okay." R64's most recent Genevive Progress Notes (physician notes) signed 8/17/18, identified R64	F 580	F580 Notify of Changes (Injury/Decline/Room, etc.) o R64 is deceased o R27 provider has been notified of illicit drug use and extended leave of absence AMA o Other residents reviewed for cough or other respiratory changes; illicit drug use and return after extended leave of absence o Education provided to nursing staff on timely notification of providers when there is a Change in condition o Audit of timely updating of provider on change in condition will be done weekly for 4 weeks and then monthly for 2 months. o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed o Compliance date. 12/5/2018	

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was seen by her medical provider who identified R64 had severe cognitive deficit related to dementia with notation, "Expect progressive decline". Further, R64's respiratory status was recorded as, "Lungs CTA [clear to auscultation] bilat [bilaterally]."

R64's progress notes dated 8/10/18 to 9/2/18, identified the following entries:

On 8/14/18, nursing staff recorded, "Message left with [nurse practitioner] regarding new order for PT/OT therapy for resident right hand."

No further progress notes were recorded until 9/1/18, when R64 was recorded as, " slightly congested. [vital signs] within normal limits. Resident was up for meals. Staff will continue to monitor." However, later on 9/1/18, "[R64] looks weak and tired, on auscultation, lung sounds congested bilaterally cough syrup Robitussin 5cc (cubic centimeters) given and resident was noted trying to cough up secretions. Resident was brought out to the dining room but did not beat [sic], however, vital signs [within normal limits]."

On 9/2/18, R64 was recorded as having a deteriorating condition and then expired.

R64's medical record lacked any evidence R64's medical provider or physician had been notified of her sudden development of congestion and corresponding lung sounds, nor was there any evidence an antibiotic had been started or attempted prior to R64's death even though R64's POLST identified acceptable interventions and treatment were, "All antibiotics okay."

When interviewed on 10/17/18, at 9:39 a.m.

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trained medication aide (TMA)-A stated R64 seemed to start "slowing down" in the weeks leading up to her death, however, R64 was not on hospice or expected to pass away when she did.

During interview on 10/18/18, at 10:29 a.m. registered nurse (RN)-A stated the nurse working when R64 had a change in condition may have called and forgot to document it accordingly, however, RN-A added, "If its not written down, it didn't happen." Further, RN-A stated the standard of practice dictated R64's physician should have been updated when she developed congestion and poor lung sounds.

R27's significant change minimum data set (MDS) of 8/13/18, identified R27 had moderate depressive symptoms. The MDS indicated R27 required limited assistance with mobility related to weakness. The diagnoses listed on R27's MDS included; cancer, seizure disorder, weakness, repeated falls, and intent to commit self harm. R27's Care Area Assessment (CAA) worksheet for Psychosocial Wel-Being dated 9/29/18, completed by social services (SS)-B identified R27 expressed little interest or pleasure in doing things. the CAA indicated this concern would be addressed in R27's care plan to address symptom relief or palliative (An approach that improves the quality of life) measures.

A review of R27's comprehensive care plan with initiation 6/22/18, and revisions made on 8/22/18, lacked identification of alteration in psychosocial well-being as an identified problem of the care

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plan.

R27's diagnostic assessment dated 9/7/18, from the in house psychologist identified R27 expressed a variety of emotions which included; boredom, loneliness, and uncertainty as to what he was to do. The note indicated R27 experienced shortness of breath and panic symptoms intermittently and indicated R27 had endorsed flashbacks with intermittent nightmares about his abusive past. The recommendations made at this time included diversional activities such as coloring books, checking in regarding thoughts of self harm or harm to others, and normalizing grief and a variety of emotions. Although recommended by psychologist, the care plan lacked the inclusion of the identified behaviors and recommended interventions. (not sure if needed)

A nursing home physician's progress note of 10/2/18 by nurse practioner (NP) indicated R27 was observed smoking illicit drugs at facility. R27 departed the facility grounds once found with the substance. The assessment and plan identified when R27 returned to the facility, staff were to monitor respiratory status with regard to regular narcotic use. The progress note also identified staff were to provide supportive care and a safe environment.

A review of the narrative Progress Notes lacked information regarding the incident of 10/2/18 as had been outlined by the NP in the nursing home physician's progress note. The Progress note of 10/2/18 at 1:56 p.m. merely stated "Resident is out on LOA [leave of absence]." The Progress Note of 10/3/18 at 1:11 a.m. indicated R27 remained out of the facility against medical advice

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(AMA) and a police report was filed. .

A narrative note of 10/10/18 indicated R27 returned from leave of absence (LOA). The note identified R27 "Was educated about the Alcohol and Substance Abuse policy" by the administrator and stated he would not use anymore. The documentation identified R27 was also offered treatment or counseling and did not wish to pursue this. The documentation lacked information of assurance of no continued illicit drug use by checking R27's personal property with permission. The documentation lacked information regarding monitoring resident for signs of use of illicit drugs upon return with completion of vital signs (Heart rate, respiratory status (breathing), blood pressure), pupil appearance and behavior. The previous recommendation from the NP on 10/2/18 was to monitor respiratory status. The documentation also lacked notification of the NP or primary provider.

On 10/16/18, 9:34 a.m. stated he had historically experienced feelings where he felt the desire to hurt either himself or hurt others but was not experiencing them now. R27 stated at those times, he left the facility for a while, going to the encampment (homeless camp), or rode the bus. R27 stated he continued to have a case worker outside of the facility and spoke with other residents.

On 10/18/18, at 2:42 p.m. R27 stated while on leave on absence, he would often ride the train. R27 stated he has used meth, not crack, and has kept some "over" from his LOA's in the past but didn't have any at that time. R27's tone then became more hostile in nature and stated "If you

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want to be a cop, get a lawyer. Get out of here I don't to talk to you. You want to be a Lucy Loo (Asian investigator), then lets end this conversation."

On 10/19/18, at 9:02 a.m. registered nurse (RN)-A stated R27 after being found with an illicit drug, left the facility for approximately one week. Upon resident return, RN-A stated he would expect an assessment to be completed including a physical assessment, pain assessment, visual inspection of body, and vital signs and immediate notification of the provider of the resident's return. A review of R27's vital sign documentation reflected the most recent monitoring to have been completed on 9/17/18. RN-A stated if a resident were to continue to use illicit drugs and returned to use of prescription drugs there could be a drug reaction as resident is on narcotics (controlled pain medications). RN-A stated he would also expect an interdisciplinary team meeting to address the plan of care for R27 with the information relayed to staff provided to care givers. RN-A stated this follow through should be documented.

On 10/19/18, at 9:29 a.m. the administrator stated this was a first time event for R27 on 10/2/18. The event was observed by the director of nursing (DON) and the police were notified. As administrator, she authorized his return to the facility and met with him upon his return and was not aware of any effects of illicit drug use. Upon review of the Progress Notes, the administrator stated the record did not reflect any monitor of vital signs, respiratory status, behaviors exhibited, or notification of the provider.

On 10/19/18, at 9:44 a.m. the DON stated she

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had observed incident and once observed R27 ran out of room. The DON stated the documentation did not reflect this. Upon R27's return, the DON stated she had observed R27 and he appeared to have an improved mood, improved color and "didn't demonstrate any signs of being under the influence." The DON stated the charge nurse was to have initiated a readmission assessment due to the length of time gone from the facility, This assessment would include a full assessment, with vista signs and review of systems. Upon review of the record, the DON stated this had not been completed. Additionally, the DON stated it would be her expectation that the provider be notified at the time of return.

On 10/19/18, at 9:59 a.m. the NP stated she was present at the time R27 left the facility and described R27 as "angry and out of control." NP stated she had instructed the facility to monitor his condition if/when he returned, especially related to his respiratory status and his current orders for narcotic use. The NP stated it would be her expectation for facility staff to assess for illicit drug use, indicating vital signs should be monitored for at least the first 24 hours and a physical assessment completed. The NP stated she would expect provider notification at the time of resident return to review his present status and to determine if there were any need for medication changes. The NP stated she was alerted at some time of his room but was unable to recall exactly when. The NP stated she was not called upon R27's return to discuss present condition and plans for current orders.

A facility Notification to Physician/Family/Resident Representative of Change in Resident Health

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F 580	Continued From page 16 Status policy dated 11/2016, identified the facility would notify the physician when a resident had an acute illness or a significant change in their status which included, " ... deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications."	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		12/5/18

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(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure personal privacy by unnecessarily exposing body parts during provision of care for 1 of 3 residents (R2) whose morning cares needing staff assistance were observed.

Findings include:

R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness) and was totally dependent on staff for their activities of daily living (ADLs). Further, R2's care plan dated 4/25/18, identified R2 was totally dependent on staff for their ADL care.

During observation of cares on 10/17/18, at 9:06 a.m. R2 was laying in bed and nursing assistant (NA)-B and NA-F entered R2's private room and explained aloud they were going to perform morning cares and closed the door to the room. R2's bedding was removed from her mid chest and pulled down to the foot of the bed exposing R2 who was dressed in a hospital style gown. R2's gown was completely removed exposing her breasts, abdomen and her soiled incontinence brief.

NA-F washed R2's exposed upper torso with a cloth and NA-B dried her skin. NA-B then opened R2's soiled incontinence brief exposing her

F 583

F583 Personal Privacy/Confidentiality of Records
- o R2 has been provided personal cares with privacy
- o Other residents reviewed for dependence to determine privacy needs during personal cares
- o Education provided to nursing staff on providing privacy during personal cares
- o Audit of privacy during personal cares completed 2 times weekly for four weeks and monthly for 2 month
- o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed
- o Compliance date. 12/5/2018

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genitals and completed perineal cares. R2 was assisted to turn onto her right side and NA-B washed her buttocks. A clean incontinence brief was placed underneath R2 who was then assisted back to a lying position in bed. NA-B and NA-F continued to clean R2's lower extremities for several minutes exposing her breasts and genitals without being covered up by NA-B and NA-F. NA-B then secured R2's incontinence brief and no longer exposing her genitals; however, R2's upper torso and breasts remained exposed throughout the provision of perineal care and changing her soiled incontinence brief. Approximately 30 minutes after R2's gown was removed and care started, NA-B and NA-F started to dress R2 for the day with a clean shirt and pants no longer exposing her upper torso and breasts.

NA-B and NA-F were interviewed immediately following. NA-F stated they closed the doorway to R2's room for cares, however, they should have covered R2's exposed skin during cares. NA-B acknowledged the same.

When interviewed on 10/17/18, at 10:04 a.m. licensed practical nurse (LPN)-A stated staff should not completely remove R2's gown exposing her entire torso and genitals areas during care. LPN-A added staff should cover up a resident while caring for them to maintain their privacy.

During interview on 10/19/18, at 9:19 a.m. director of nursing stated staff were instructed to only expose and uncover areas necessary to clean and should then cover the exposed area immediately after finishing. This was important to ensure a residents privacy during cares.

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F 583	Continued From page 19 A policy on personal privacy during cares was requested and not received.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		12/5/18

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F 585	Continued From page 20 grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,	F 585		

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F 585	Continued From page 21 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident grievance were acted upon timely for 2 of 2 residents (R62, R115) who voiced concerns about their room-delivered meal trays. Finding include: R62's admission Minimum Data Set dated 10/3/18, identified R62 was able to understand others and express her own needs and wants with no difficulty. The MDS also indicated R62 was cognitively intact. During interview on 10/15/18 at 3:27 p.m. R62 voiced numerous concerns about food service in the facility. R62 stated she did take "room trays" meaning she did not go to the dining room for her	F 585	F585 Grievances o R62 no longer resides at the community o R115 no longer resides at the community o Other residents interviewed to determine their meal preferences o Education provided to IDT on grievance process o Audit by interviewing 5 residents for meal preferences two times per week for four weeks and then monthly for two months o Audit 5 resident's meal selections two times per week for four weeks and then monthly for two months to determine requests are being met o E.D. will review all grievances weekly	

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F 585	Continued From page 22 meals, but instead chose to eat in her room. R62 stated it seemed there was always something wrong. In a later interview on 10/16/18 at 1:33 p.m. R62 stated with her meal tray was not sometimes delivered hot, or sometimes "it just didn't look good," or if you get coffee, and put down on the menu slip that you want creamer or sugar, "you just don't get it" and you end up having to ask again for it. R62 stated she did report this to staff, admitting she can be very verbal about expressing her needs. R62 stated each time something was left off her tray, she would tell at least one staff "if they ever came back to the room." R62 stated staff were "certainly aware of what I wanted," and also stated she was "frustrated" saying "this ain't no Holiday Inn." During observation on 10/17/18 at 8:08 a.m. nursing assistant staff were passing meal food trays with covered meal plates, which had been removed from a portable food cart parked near the nursing station, then loaded onto smaller cart. Among the trays staff were passing included a breakfast tray for R62. At 8:19 a.m. nursing assistant (NA)-B delivered a meal tray into R62's room. R62 was seated upright on her bed, and immediately when looking at the meal tray told NA-B "they forgot my coffee, and I bet they don't have sugar for my oatmeal." R62 looked at her tray, and removed the top plate cover. Underneath was a small omelette, and a lidded bowl of oatmeal. In addition to the food items, there was a 4 ounce glass of milk. The tray had no other beverages on, and there was no sugar of any kind on the plate. R62's meal tray had paper menu slip, with R62's choices circled, including coffee and sugar. At 8:30 a.m. NA-B returned to R62's room and brought a mug of	F 585	and assure timely follow-up per policy o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed. o Compliance date: 12/5/2018	

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coffee and several packages of sugar for R62.

When interviewed on 10/17/18 at 8:51 a.m., NA-B stated R62 "did not get sugar" on her plate this morning. NA-B stated she had to go back and get the sugar and coffee. NA-B stated the kitchen normally sets up the trays, and they are supposed to put everything on the tray "what the residents want and that they can have." NA-B stated she knows R62 liked sugar, "but it just wasn't on the plate." She was unsure why.

R115 was admitted to the facility on 10/2/18, as identified on an undated resident census roster.

During interview on 10/15/18 at 5:35 p.m. R115 stated during her life she worked as a cook, adding she was on no special diet and described the food as "pretty so, so" and that "sometimes they just miss little things." R115 stated they might miss putting sugar on the plate, and then you have to tell someone, ask for it, then wait. R115 stated she does tell staff if she notices something is missing, and they have to go back to get it, and then sometimes your food gets cold while waiting for the staff to come back.

During observation on 10/17/18 at 8:38 a.m. R115 was sitting on the edge of her bed in her room with a meal tray that contained, a slice of toast, two small, single-serving packages of strawberry jam, a cup of coffee, a small glass of milk, and a covered bowl of hot cereal on her bedside table. R115 stated she, "need sugar for my oatmeal" and the staff coordinator (SC) who was outside R115's room overhead the conversation and informed R115 she would get some. At 8:43 a.m. SC returned with four, single

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serve packages of sugar and give them to R115.

When interviewed on 10/17/18 at 8:44 a.m. staffing coordinator (SC) stated kitchen staff are the ones who set up the resident meal trays, SC said she helped pass trays today, and stated R115's tray did not have any sugar on her meal tray, and she had to go back to bring additional sugar for her. The SC stated the kitchen staff "should be putting sugar and jam" on the plates for toast, cereal and coffee. "It got missed," and was unsure why.

When interviewed on 10/18/18 at 10:03 a.m. the head cook (HC) stated when he gets resident menu slips, he puts the main food items on the trays and the aides were responsible to put condiments on the meal trays, like creamer, sugar packets, jam, butter. The HC stated the residents had to circle what they wanted every day, and if a resident does not circle the menu item "it does not get put on the tray." The HC stated he does not get feedback if things were missed on the trays, and also stated residents should have sugar for coffee and cereal or if they wanted butter and jam. These items should be on the menu slip and also on the trays.

When interviewed on 10/18/18 at 11:45 a.m. the registered dietician (RD) talked about serving residents in their rooms and the challenges it presented. The RD stated the resident choice or menu slips were filled ahead of time, which were then were used to put together the meal trays. The RD stated "it is frustrating" for a resident to get their meal but not get the salad dressing, or butter or sugar. The RD stated residents were highly encouraged to take their meals in the dining room, so that if they were missing

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F 585	Continued From page 25 something, it could be quickly addressed. The RD also stated resident should have what they need for their meals, no matter where it was served. When interviewed on 10/17/18 at 12:57 p.m. the facility administrator stated they had system to deliver meal trays to resident room and meet their food needs however, "We may have to look at the process."	F 585		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a	F 622		12/5/18

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F 622	Continued From page 26 resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)	F 622		

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F 622	Continued From page 27 (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide resident transfer information to the receiving facility for 2 of 2 residents (R3 and R55) reviewed for hospitalization and discharge. Findings include: R3's quarterly Minimum Data Set (MDS) indicated R3 had intact cognation and had an indwelling catheter with mechanical complications. R3's Census List dated 10/18/18, indicated R3 was hospitalized on the following dates: 6/22/18, 7/6/18, and 10/5/18. A review of R3's Progress Notes of 6/22/18, at 6:18 p.m. indicated resident was experiencing	F 622	F622 Transfer and Discharge Requirements o R3 returned to the facility without discharge paperwork being sent to hospital stay o R55 no information received in 2567 to know what to address with this resident o R66 has discharged from the facility o Other residents have had appropriate paperwork sent with to hospital visits o Reviewed last 30 days of discharge to ensure residents had appropriate o Education provided to IDT and licensed nurses on discharge procedure including accompanying information and necessary documentation for discharge. This will apply to emergency transfers as well.	

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F 622	Continued From page 28 problems with draining of Foley catheter and irrigation of the catheter provided limited results. The note identified R3 was sent to the emergency room (ER) for evaluation. There was no indication the resident contact information, advance directive, history of urinary tract infections, and baseline information (including current status, mental and cognitive status, reason for transfer, recent vital signs, current medication orders) and information about problems with R3's indwelling catheter were sent to the ER/hospital for R3 for continuity of care. The following Progress Note of 6/25/18, at 3:45 p.m. indicated R3 returned from the hospital with the diagnoses of sepsis, possible urinary tract infection (UTI) and chronic urinary retention with an indwelling catheter. The record lacked a documentation to reflect what, if any, transfer report/forms/information was sent for the receiving provider upon initial transfer to the ER/hospital for evaluation including R3's contact information/current diagnosis, medication use, advance directives, comprehensive care plan goals, and information pertinent to proving R3 care. . R3's Progress Notes of 7/6/18, of 4:04 p.m. identified R3 was sent to the ER for urinary retention. The documentation failed to identify what information was sent with R3 to provide baseline information for R3's contact information/current diagnosis, medication use, advance directives, comprehensive care plan goals, and information pertinent to proving R3 care. R3's Progress Notes of 10/5/18, of 3:31 a.m. indicated that resident was sent to the ER via	F 622	o Administrator or designee to audit with each transfer for one month and monthly for 2 months o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed. o Compliance date: 12/5/2018	

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non-emergency ambulance. The documentation failed to identify what information was provided to the receiving facility to enable them to serve R3 based on his identified needs. This information would include R3's contact information/current diagnosis, medication use, advance directives, comprehensive care plan goals, and information pertinent to proving R3 care. A follow up note at 7:48 a.m. identified resident was admitted to the hospital related to UTI resistive to oral antibiotics and need for intravenous (IV) antibiotics.

On 10/18/18, at 9:37 a.m. registered nurse (RN)-A stated when resident's were transferred to the ER or hospital, copies were sent of documents including; the face sheet, Physician's Orders for Life Sustaining Treatment (POLST), MAR's, labs and any other information as indicated. The documentation should reflect what was sent with upon transfer. RN-A was unable to provide documentation to reflect what was sent with on R3's past hospitalizations. RN-A stated there was a transfer form which could be used, but this was not used for R3. RN-A stated staff did not routinely document forms which were sent with to the hospital. RN-A stated the emergency medical service did not transport residents without the correct paperwork. .

On 10/19/18, at 10:29 a.m. the director of nursing (DON) stated the facility did not use a transfer form for residents going to the ER or hospital. The DON stated upon transfer to the ER/hospital, the nurse should send a copy of the following; the face sheet, a recent history and physical, most recent lab, the POLST, and a copy of the care plan. The DON stated R3's documentation did not reflect this was sent. The DON stated at times a verbal report is called, however, the DON stated

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this should be documented and was not indicated in R3's record.

A policy for transfer of residents to the hospital was requested and was not received.

R66's discharge MDS of 7/30/18 indicated R66 had intact cognition and was independent with all cares.

R66's care plan was initiated on 4/20/17, and indicated R66 desired return to the community and requested housing assistance. The care plan was revised on 2/21/18 indicated a referral to outside agency for an assessment to receive services under Community Access for Disability Inclusion(CADI) waiver was made.

R66's Progress Note of 3/15/18, indicated social services was working with R66 on his discharge plan. R66 was identified as ineligible for CADI, however, reported he was working with Citizens Disability and was awaiting follow up from the State Medical Review Team (SMRT) which determined disability.

R66's Care Conference Summary completed on 6/27/18, indicated discharge was anticipated on 7/3/18. It was identified that resident was working on follow up visit with primary care physician and pharmacy.

R66's Progress Note of 6/27/18, indicated orders were received from primary care provider to initiate diabetic education which was to include glucose monitoring, appropriate insulin self dosing and administration. The progress notes of the primary care provider indicated R66 was to

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follow up in one month.

On 7/22/18, at 15:48 (3:48 p.m.) it was identified that resident went on an LOA and took along his blood glucose supplies and insulin. The documentation identified resident demonstrated "appropriate understanding of the procedure".

R66's Progress Note of 7/2/18, at 4:09 p.m. indicated diabetic education was provided, however, the documentation failed to identify what information was provided, and failed to include any written information to reflect this. The documentation indicated R66 understood the education provided and self administered insulin properly, however, the documentation lacked information as to information provided, R66's understanding of the process, and any pertinent notes. The medication administration record (MAR) directed staff to "Initiate diabetic education for residents discharge. Teach glucose monitor and insulin administration. " The MAR indicated this was completed on all three shifts for the month of July , with only two shifts lacking documentation, however, the MAR notes, and the narrative Progress Notes do not indicate R66's understanding or performance of the tasks.

R66's Progress Note of 7/30/18, at 12:46 p.m. identified resident was discharged to his home with his clothes, personal property, and insulin. The documentation failed to indicate R66 was provided with discharge instructions, equipment provided, where to obtain equipment needed, or any medical follow up indicated. R66's record lacked additional forms or documentation with this information.

R66's Interdisciplinary Discharge Summary,

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signed by staff on 7/27/18, identified R66 was ambulatory short distances, but required the use of a wheelchair. The medication identified under the heading of Medication at Discharge indicated R66 was to receive Humalog (insulin) 10 units (a measurement used to measure dosing) three times a day, and Basglar(insulin) 50 units at bedtime. The summary did not identify the frequency R66 was to monitor blood sugars with the use of monitor. The documentation lacked information regarding the symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) or what was to be done if either occurred.

On 10/18/18, at 9:37 a.m. registered nurse (RN)-A stated the original transfer papers provided upon discharge had been given to the resident, however, a copy was not retained for the record. RN-A stated the narrative documentation does not reflect what was provided/reviewed with resident.

On 10/19/18, at 10:29 a.m. the DON stated upon discharge from the facility it would be anticipated a copy of the discharge instructions would be reviewed with resident and a copy would be placed in the resident's record. This information should include information which was needed to manage at home, which for R66 would include diabetic management, medication orders, recommendations for follow up with the provider, contact information and resources needed.

A facility policy Admission, Transfer, Discharge (General) revised 9/22/17, identified information to be provided upon transfer to an alternative provider would include the follow; history of present illness, reason for transfer and past

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F 622	Continued From page 33 medical history, contact information for provider and resident representative, advanced directive information, all special instructions or precautions, comprehensive care plan goals, and all any other documentation to ensure "a safe and effective transition of care."	F 622		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		12/5/18

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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 35 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Ombudsman of transfers and discharge for 3 of 3 residents (R3, R66, and R2) reviewed for hospitalizations and/or discharges. This had the potential to affect all 62 residents who resided in the facility as the facility identified they were unaware of the requirement. Finding includes: R3's quarterly Minimum Data Set (MDS) indicated R3 had intact cognation and had an indwelling catheter with mechanical complications.	F 623	F623 Notice Requirements Before Transfer/Discharge o Long Term Care Ombudsman has been notified of R3 hospital visits on 6/22/18, 7/6/19 and 10/5/18 o R66 has discharged from the facility o Long Term Care Ombudsman has been notified of R2 hospital visits on 2/3/18 and 4/6/18 o All other residents with hospitalization in month of October 2018 have been reviewed and Long Term Care Ombudsman update per requirement	

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Continued From page 36

R3's Census List dated 10/18/18, indicated R3 was hospitalized on the following dates: 6/22/18, 7/6/18, and 10/5/18.

A review of the R3's documentation lacked indication of notification of the ombudsman for R3's hospitalizations of 6/22/18, 7/6/18, and 10/5/18. A request was made for documentation to reflect the ombudsman was notified of the hospitalized, however, no information was provided.

R66's discharge MDS of 7/30/18 indicated R66 had intact cognition and was independent with all cares.

R66's Progress Note of 7/30/18, at 12:46 p.m. identified resident was discharged to his home with his clothes, personal property, and insulin.

A review of R66's documentation lacked notification of the ombudsman of R66's discharge to home on 7/30/18. A request was made for documentation to reflect the ombudsman was notified of the discharge, however, no information was provided.

On 10/18/18, at 11:30 a.m. social services (SS)-A stated the nursing home administrative staff and consultants were unaware of this requirement and this had not been implemented for transfers and discharges from the facility prior to this time.

R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent

F 623

o Education provided to IDT on fax communication form required monthly to update Ombudsman of transfers and discharges, including emergency care.
o Administrator or designee to audit monthly for 3 months
o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed.
o Compliance date: 12/5/2018

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F 623	Continued From page 37 vegetative state (no discernible consciousness) R2's undated, Census List identified the following hospital leaves: - R2 was hospitalized on 2/3/18, returning to the facility on 2/8/18. - R2 was hospitalized on 4/6/18, returning to the facility on 4/8/18. R2's medical record lacked notification of the hospitalizations to the Long Term Care Ombudsman (LTCO). During interview on 10/18/18, at 3:03 p.m. the administrator stated the facility was not notifying the LTCO of any resident hospitalization and were not aware of this requirement. Tha facility had not notified the LTCO of any residnet hospitalizations.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		12/5/18

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F 625	Continued From page 38 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide resident transfer information to the receiving facility for to 2 of 2 residents (R3 and R55) reviewed for hospitalization. Findings include: R3's quarterly Minimum Data Set (MDS) indicated R3 had intact cognation. R3 was identified as having an indwelling catheter with mechanical complications. R3's Census List dated 10/18/18, indicated R3 was hospitalized on the following dates: 6/22/18, 7/6/18, and 10/5/18. R3's Progress Note of 6/22/18 at 6:18 p.m. indicated resident was experiencing problems with his Foley catheter and identified he was sent to the emergency room (ER) for evaluation. The record lacked documentation of notification of the resident/family representative of the bed hold policy.	F 625	F625 Notice of Bed Hold Policy Before/Upon Trnsfr o R3 returned to the facility prior to receiving bed hold o R55 has discharged from the facility o Other residents have received bed hold per policy o Education provided to IDT and licensed nurses to obtain signed bed hold on all transfers including emergency care o Administrator or designee to audit with each transfer for one month and monthly for 2 months o Audits will be reviewed by QAPI for 3 months to review and recommend follow up as needed. o Compliance date: 12/5/2018	

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F 625	Continued From page 39	F 625		

R3's Progress Notes of 7/6/18 of 4:04 p.m. identified R3 was sent to the ER for urinary retention and was subsequently admitted to the hospital. The documentation lacked evidence of notification of resident/family of the bed hold policy.

R3's Progress Notes of 10/5/18, at 3:31 a.m. indicated that resident was sent to the VA ER via non-emergency ambulance per narrative of 10/5/18. A follow up note of 7:48 a.m. identified resident was admitted to the hospital. The documentation did not reflect either resident or responsible party were notified of the bed hold policy.

On 10/18/18, at 10:17 a.m. registered nurse (RN)-A stated a bed hold notification was provided to the resident/responsible party upon a resident's transfer to the ER/hospital and this documentation/form should be easily found within the resident record. RN-A was unable to provide information regarding provision or documentation of the bed hold policies being provided to R3 upon hospitalization on the above listed dates.

R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness) Conditions identified were a progressive cerebrovascular disorder caused by blocked arteries at the base of the brain and paralysis.

R2's undated, Census List identified the following hospital leaves:

- R2 was hospitalized on 2/3/18, returning to the facility on 2/8/18.

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F 625	Continued From page 40 - R2 was hospitalized on 4/6/18, returning to the facility on 4/8/18. R2's medical record lacked evidence a bed hold policy was provided to R2's representative when hospitalized. R2's progress notes from 2/3/18, through 4/10/18, did not identify R2's respresentive was provided the bed hold policy. During interview on 10/18/18, at 3:03 p.m. the administrator stated a bed hold policy was supposed to happen prior to planned hospital leave or given on transfer to the hospital. The facility social worker would follow up with family to get a verbal confirmation of the bed hold and let them know the policy was sent with the resident to the hospital and also offer to mail a copy. The bed hold policy was supposed to be filed in the resident medical record. The facility was not currently upholding denial of return to the facility for residents that did not sign a bed hold because of low facility census. However, if the census was higher, holding a bed could have financial ramifications and/or the resident would not return to the facility if there were no available beds . The administrator was aware resident had not been receiving bed holds when transferred to the hospital and staff needed to be educated on this process. An undated, facility Bed Hold Policy and identified when the resident was transferred to a hospital or goes on therapeutic leave, they were to be informed in writing of the facility bed hold policy which provided the individuals of their financial rights and responsibilities.	F 625		
F 636	Comprehensive Assessments & Timing	F 636		12/5/18

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F 636 SS=D	Continued From page 41 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 636		

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F 636	Continued From page 42 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess a residents risks for falls using the Resident Assessment Instrument (RAI) process for 1 of 2 residents (R2) reviewed for falls. Findings include: R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness), had paralysis of all four limbs, and had sustained two or more falls without injury since the last MDS was completed on 6/26/18. R2's progress notes from 6/26/18, through	F 636	F636 Comprehensive Assessments and Timing o R2 has been comprehensively assessed for falls using the RAI process o All other residents who have had falls in the last 30 days have had comprehensive assessment for falls using the RAI process o Education provided to MDS nurse on comprehensive falls assessment by using the RAI process. o Audit of comprehensive falls assessment in accordance with RAI will be completed two times weekly for four weeks and monthly for two months o DON/ Designee will report results and	

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F 636	Continued From page 43 9/25/18, identified R2 had one fall on 7/4/18. The progress noted dated 7/4/18, identified R2 had a fall from bed which resulted in a minor injury of bruising to the face, an abrasion to her right knee and a small laceration above her left eye. This was the only fall identified from 6/26/18, to 9/25/18. R2's fall Care Area Assessment (CAA) dated 10/9/18, identified R2 had a potential problem/need related to falls. The MDS identified a need for a comprehensive assessment related to R2's balance problems and recent fall history. The CAA identified R2 was at risk for falls and contained system generated pre-populated information related to R2 having difficulty maintaining a sitting balance, impaired balance during transitions, diuretic medications, strokes, incontinence, and dementia. The environmental factors was not reviewed and were left blank along with no analysis of R2's falls. The resident/ family input section was also blank. The CAA identified R2's fall risk would be care planned and did not identify a goal. Further, the rationale section included information that R2 had no falls and needed staff assistance for mobility. The CAA did not identify or address the underlying cause(s) of the resident's fall(s), or any contributing risk factors. On 10/19/18, at 8:34 a.m. registered nurse (RN)-C reviewed R2's fall CAA and stated it virtually only contained the system pre-populated checks from the MDS. The fall analysis was inaccurate as R2 had two falls in the past year. She did not talk with family during the the assessment process to receive their input on R2's fall risk. Further, the CAA should contain an assessment of the residents falls, their risk factors, interventions in use, or any previous	F 636	trends of all audits to QAPI Committee for 3 months to review and follow-up as needed o Compliance date 12/5/2018	

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F 636	Continued From page 44 interventions that failed. This information was important to help develop a comprehensive care plan to minimize the residents risk of falling. The MDS 3.0 RAI Manual v 1.15 dated 10/17 identified "The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident ' s functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care."	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the falls on the Minimum Data Set for 1 of 2 residents (R2) reviewed for falls. Findings include: R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness) R2 was identified to have two or more falls without injury since the last MDS dated 6/26/18. R2's progress notes from 6/26/18, through 9/25/18, identified R2 had one fall on 7/4/18. The progress noted dated 7/4/18, identified R2 had a	F 641	F641 Accuracy of Assessments o R2 has had MDS modification to accurately code the fall with injury o All other residents with falls will be reviewed for MDS accuracy and corrections made if identified o Education provided to MDS nurse on accuracy of CAA and MDS for falls o Audits will be conducted two times per week for 4 weeks and then monthly for 2 months to ensure CAA and MDS accurately reflect resident's bowel and bladder devices. o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as	12/5/18

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F 641	Continued From page 45 fall from bed which resulted in a minor injury of bruising to the face, an abrasion to her right knee and a small laceration above her left eye. There was no indication R2 had a second fall, as identified by the 9/25/18 MDS. On 10/19/18, at 8:34 a.m. registered nurse (RN)-C reviewed R2's fall history and compared the information to the annual MDS dated 9/25/18. RN-C stated the MDS was coded incorrectly. The MDS should have identified R2 had one fall with injury except major versus two or more falls without injury. RN-C was responsible for completing the MDS' and did not know why the MDS was coded incorrectly; however, the fall status should be accurately reflected. The MDS 3.0 RAI Manual v 1.15 dated 10/17, identified the staff should "Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury."	F 641	needed o Compliance date 12/5/2018	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		12/5/18

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F 655	Continued From page 46 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop an initial care plan based on resident admission needs for 2 of 2 residents (R62 and R63) reviewed in the	F 655	F655 Baseline Care Plan o R62 no longer resides at the facility o R63 has had a baseline care plan completed	

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F 655	Continued From page 47 sample for care planning. Findings include: R62's diagnoses, as identified on the Omniview Resident Profile, printed 10/16/18 included post-op back pain, chronic post-op pain, and flat back syndrome. R62's Minimum Data Set (MDS) dated 10/3/18 indicated she was admitted to the facility on 9/26/18 from an acute-care hospital. The MDS indicated R62 had intact cognition. A Pain Management Consult dated 9/25/18, indicated R62 was evaluated for post-operative pain management, having complained of bilateral leg pain and numbness. The report indicated R62 was a highly, opiate-tolerant individual, who recently underwent a large, spinal reconstructive surgery. R62 had been on OxyContin (an opiod pain medication) and oral Dilaudid (pain medication), and R62 stated her pain was "at about an 8 to 9" (based on pain scale 1 to 10). The report also indicated R62 had history of illicit drug use, had used an illicit drug prior to recent surgery, but denied using on a regular basis. The provider indicated reluctance to increase opioids at this time, but did prescribe Lyrica and Flexeril (a muscle relaxant). R62's admission progress note dated 9/26/18, indicated R62 was admitted to the facility at 3 p.m. from Abbott Northwestern Hospital. Admitting diagnoses: spinal reconstructive surgery, chronic pain and depression. Resident alert and oriented x (times) 3, able to communicate needs. States that her pain level is 10/10. Pain meds (medications) to be administered as soon as they are available.	F 655	o All other recently admitted residents will be reviewed and baseline care plan completed if indicated o Education provided to the IDT and nursing staff on timely baseline care plan development to meet immediate needs of newly admitted residents. o Audits will be conducted with each admission for 4 weeks and then monthly for 2 months to ensure completion all newly admitted residents have a baseline care plan developed timely. o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date. 12/5/2018	

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F 655	Continued From page 48 During observation on 10/16/18, at 1:53 p.m. R62 was lying on the top of her bed in her room, dressed in short sleeve shirt, wearing pants, socks and shoes. R62 sat up in bed and pushed aside a heating pad that was on her R thigh., and R62 began rubbing her legs near her thigh and stated "they ache" R62 stated she had been to physical therapy, told the nurse she wanted a pain med (medication), "but it hasn't arrive here yet." The surveyor asked R62 to talk about her pain and R62 replied "I rate it at fifteen." At 2:08 p.m. licensed practical nurse (LPN)- entered the room and administer a pain medication to R62. After swallowing the oral pain medication, R62 stood up, transferred herself into her wheel chair. As she exited the room R62 stated "They just don't seem to get my pain. You have to wait for the pills." At the threshold of the door R62 stated "I just need to get out of this hell hole." Within the medical record was R62's Individual Resident Care Plan, dated 9/26/18. This care plan, to be developed within 48 hours of admission, was a four-column, form document, which listed typical care areas and risks, for which interventions could be "checked" from a pre-populated lists; space was also provided to write non-listed interventions. Risk and care areas included: fall risk, skin risk, pain control, bathing, dressing, ambulation, meal assistance and toileting plan. Under the "Pain Control" section, there were three pre-printed areas: Has pain or discomfort potential; location (with a blank line to fill in); use pain scale as applicable; pain management plan; and interventions (with a blank line to fill in). Nothing in the pain section of this care plan was checked in the pre-printed areas, nor was any narrative included in this section. Nowhere else on this care plan document was	F 655		

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pain addressed.

When interviewed on 10/16/18 at 2:21 p.m. R62 stated she came in the facility following back surgery, and with that "I have a lot of pain." R62 stated it seems the med passer "just never shows up." R62 stated she just a while ago got done with therapy, questioned "Do you think my meds are here." R62 stated she felt the facility "just did not get" the fact that I have pain. R62 stated she came in here after back surgery, and "wouldn't you think pain management would be addressed?"

When interviewed on 10/16/18 at 2:39 p.m. licensed practical nurse (LPN)-A stated R62 did have pain, complained of pain, and was on a number of medications to address that. LPN-A stated R62 had and also used non-pill related things to address pain, like heat. LPN-A stated that although R62 frequently asked for additional pain medications, she thought R62's pain was being managed.

When interviewed on 10/16/18 at 3:31 p.m. registered nurse (RN)-B stated R62 came to the facility on September 26th, and stated "we create a temporary care plan" for all new residents. RN-B stated the care plan should address a resident's basic needs, "for a resident's major problem why they are here" and then the care plan is updated as we go along. RN-B looked in R62's chart and acknowledged the initial care plan had nothing written or checked regarding pain for R62. In a subsequent interview at 3:52 p.m., RN-B stated addressing R62's pain "should have been" part of her care plan. RN-B stated the care plan was needed "as a guide" so that anybody, not familiar with the resident, can help

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F 655	Continued From page 50	F 655		

take care of that resident.

When interviewed on 10/18/18 at 10:54 a.m. the director of nursing (DON) stated R62 was a difficult case regarding pain management because they just stopped her pain medication when she left the hospital. The DON later stated R62's pain, and pain management, "should have been addressed" and spelled out more on R62's initial care plan.

R63's Resident Information sheet dated 10/19/18 indicated R63 was admitted on 9/26/18 with the multiple diagnoses which included; pain in her right hip, chronic pain, acute respiratory failure, heart failure, anemia, and chronic obstructive pulmonary disease (COPD).

R63's discharge orders and information summary dated 9/26/18 identified R63's diagnoses to include asthma exacerbation (worsening), acute on chronic hypoxic respiratory failure (limited air movement through the body), pulmonary hypertension (A type of high blood pressure which affects the arteries in the lungs and the right side of your heart) and acute and chronic pain. The discharge information indicated R63 required use of oxygen continuously and nebulizer, a device used to administer medication in the form of a mist inhaled into the lungs. The discharge information directed R63 should space activities to conserve energy.

R63's Progress Notes of 9/26/18, indicated R63 was alert and oriented and able to communicate her needs. R63 was identified as being independent with bed mobility, transfers, and mobility with the use of a wheelchair. R63 was identified as requiring assist with personal cares.

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F 655	Continued From page 51 On 10/16/18 1:56 p.m. R63 was observed to be neatly dressed and groomed, self propelling her wheelchair through the dining. R63 was observed to have a liquid oxygen container secured to the back of the wheelchair, with a nasal cannula in place. R63 was able to speak easily without observed shortness of breath, halted speech, or cough noted. A review of R63's documents lacked a completed baseline care plan completed within 48 hours following admission which identified her basic needs and interventions indicated related to her medical diagnoses. On 10/19/18, at 8:38 a.m. registered nurse (RN)-A stated the baseline care plan was not in the medical record and the director of nursing (DON) was completing the majority of resident care plans. On 10/19/18, at 11:07 a.m. the DON stated there should be a baseline care plan for R63. The DON stated the baseline care plan provides guidance to staff for resident's needs as identified upon admission to the facility. A policy regarding baseline care plan was requested, but none was provided. A facility policy, Person-centered Plan of Care, revised November 2016, indicated the care plan describes services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		12/5/18

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F 656	Continued From page 52 §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 plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 53 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 develop a comprehensive care plan for 1 of 1 resident (R27) reviewed for mood and behavior and 1 of 3 residents (R63) reviewed for pain. Findings include: R27's significant change minimum data set (MDS) of 8/13/18 identified R27 had moderate depressive symptoms. The MDS indicated R27 required limited assistance with mobility related to weakness. The diagnoses listed on R27's MDS included; cancer, seizure disorder, weakness, repeated falls, and intent to commit self harm. R27's Care Area Assessment (CAA) worksheet for Psychosocial Wel-Being dated 9/29/18, completed by social services (SS)-B identified R27 expressed little interest or pleasure in doing things. the CAA indicated this concern would be addressed in R27's care plan to address symptom relief or palliative (An approach that improves the quality of life) measures. R27's baseline care plan dated 6/4/18, indicated R27 was verbally abusive at times related to anxiety and had potential for alteration in anxiety. The baseline care plan directed staff to provide resident with one to one interactions and mediations as needed (PRN). A review of R27's comprehensive care plan lacked identification of alteration in psychosocial well-being as an identified problem of the care plan with initiation of comprehensive care plan	F 656	F656 Development/Implement Comprehensive Care Plan o R27 care plan reviewed and updated to reflect mood and behavior needs o R63 care plan reviewed and updated to reflect pain needs o All other residents care plans will be reviewed and updated for mood and behavior and pain needs o Education to IDT and nursing staff on comprehensive care planning for mood and behavior as well as pain needs o Audit of the development and implementation of care plan for mood and behavior and pain will occur two times weekly for 4 weeks then monthly for 2 months o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date. 12/5/2018	

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F 656	Continued From page 54 6/22/18 or revisions made on 8/22/18. The comprehensive care plan lacked information regarding resident being verbally abusive with the potential for alteration in anxiety as addressed in the base line care plan. R27's diagnostic assessment dated 9/7/18, from the in house psychologist indicated the referral was made my the medical to improve R27's quality of life. Behaviors identified in the documentation indicates R27 expressed a variety of emotions which included; boredom, loneliness, and uncertainty as to what he was to do. The note indicated R27 experienced shortness of breath and panic symptoms intermittently and indicated R27 had endorsed flashbacks with intermittent nightmares about his abusive past. The recommendations made at this time included diversional activities such as coloring books, checking in regarding thoughts of self harm or harm to others, and normalizing grief and a variety of emotions. Although recommended by psychologist, the care plan lacked the inclusion of the identified behaviors and recommended interventions. A follow up assessment of 10/12/18 identified R27 became irritable when questions were addressed related to safety concerns. and recommended caregivers remain neutral with questions/assessments and offer comfort and validation of his discomfort to maintain trust. On 10/16/18, 9:34 a.m. stated he had historically experienced feelings where he felt the desire to hurt either himself or hurt others but was not experiencing them now. R27 stated at those times, he left the facility for a while, going to the encampment (homeless camp), or rode the bus.	F 656		

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F 656	Continued From page 55	F 656		

R27 stated he continued to have a case worker outside of the facility and spoke with other residents.

On 10/18/18, at 2:42 p.m. R27 stated while on leave on absence, he would often ride the train. R27 stated he has used meth, not crack, and has kept some "over" from his LOA's in the past but didn't have any at that time. R27's tone then became more hostile in nature and stated "If you want to be a cop, get a lawyer. Get out of here I don't to talk to you. You want to be a Lucy Loo (Asian investigator), then lets end this conversation."

R27's medication administration record (MAR) for July of 2018 had an entry that staff were to monitor for signs of symptoms on antipsychotics, antidepressant and antianxiety medications. The MAR indicated there were "0" symptoms present in the month of July. A review of the subsequent month's MAR did not reflect this monitoring was to be done. This entry was not present on subsequent months.

R27's Behavior/Intervention Monthly Flow Record for July of 2018 indicated only one episode which referred the reader to the nurses notes on 7/28/18. A review of the Progress Note of 7/28/18 indicated R27 became "anxious and verbally abusive" when pain medication was not given along with his sleeping pills. The note indicated R27 was given his pain medication, sleeping medication, and antianxiety medication and no further behavior was documented.

R27's Behavior/Intervention Monthly Flow Record for August of 2018 monitored for signs and symptoms of depression, and no symptoms of

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depression was documented as indicated with a "0".

On 10/18/18, at 10:48 a.m. the social service (SS)-A stated R27's records were reviewed and lacked additional information related to mood state and behavior. SS-A stated the MDS assessment and CAA information identified areas of concerns and these should be addressed on care plan.

On 10/19/18, at 8:57 a.m. registered nurse (RN)-A stated he was aware of R27's mood and behavior concerns, but was unsure as to who would address the concerns in the absence of a social service staff member.

On 10/19/18, at 9:25 a.m. the administrator stated the record did not reflect address R27's mood state or altered behavior in the care plan.

On 10/19/18, at 9:44 a.m. the director of nursing stated R27 has had some mood changes and this should be reflected in the care plan. The DON stated R27 is currently being followed by the in house psychologist for his concerns, and that also should be reflected in the care plan.

R63's Progress Notes of 9/26/18, indicated R63 was alert and oriented and able to communicate her needs.

R63's Resident Information sheet dated 10/19/18 indicated R63 was admitted on 9/26/18 with the multiple diagnoses which included; pain in her right hip, chronic pain, acute respiratory failure, heart failure, anemia, and chronic obstructive pulmonary disease (COPD).

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F 656	Continued From page 57	F 656		

R63's discharge summary dated 9/26/18 identified R63's diagnoses to include asthma exacerbation (worsening), acute on chronic hypoxemic respiratory failure (limited air movement through the body), pulmonary hypertension (A type of high blood pressure which affects the arteries in the lungs and the right side of your heart) and acute and chronic pain. The discharge identified R63 required use of oxygen continuously and nebulizer (process to administer medications to the lungs) therapy.

On 10/15/18, at 2:42 p.m. R63 stated she was supposed to have had a conference in the morning, however, it was rescheduled and she had not heard anything in follow up.

On 10/19/18, at 8:38 a.m. registered nurse (RN)-A stated the director of nursing (DON) completed the majority of the care plan development.

On 10/19/18, at 11:07 a.m. the DON reviewed a care plan outlined in R63's record. The care plan on record was initiated on 1/13/16 with a prior admission and addressed the following problems; R63 was a vulnerable adult related to residing at a skilled nursing facility, R63 was admitted to the facility as a short term with plans to return home, and addressed the staff as to R63's advanced directive wishes. R63's mood and behavior status was addressed also. The target date for these problems were identified as 1/16/16. An additional care plan problem was identified which identified R63 as a new admission with lack of familiarity with policies and procedures. This goal target date was amended to 10/16/18. Additional care plan was imitated on 10/3/18 and addressed

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F 656	Continued From page 58 R63's risk for nutritional status related to multiple medical diagnoses. Additionally the care plan identified R63 was a smoker and uses oxygen. The care plan failed to address R63's concerns related to respiratory status related to pulmonary hypertension, heart failure, edema, pain management, need for assist with personal cares, or discharge planning. The DON stated these areas should have been included in the current care plan. A policy was requested for care plan development was requested and was not received.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		12/5/18

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F 657	Continued From page 59 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 1 of 1 residents (R27) who used illicit drugs and had episodes of unexpected leave of absence. Findings include: R27's significant change minimum data set (MDS) of 8/13/18 identified R27 had moderate depressive symptoms. The MDS indicated R27 required limited assistance with mobility related to weakness. The diagnoses listed on R27's MDS included; cancer, seizure disorder, weakness, repeated falls, and intent to commit self harm. R27's care plan initiated 6/6/18 lacked identification of resident concerns related to mood state, psycho-social well-being, and psychotropic drug use (R27 had orders for antipsychotics, antidepressants, and antianxiety medications). R27's Nursing Home Visit-Progress note of 10/2/18, identified R27 was observed with illicit drugs at the facility and concerns were identified with the potential interaction with illicit drugs and controlled medications. The provider indicated upon return, R27 must be monitored for respiratory status with regard to regular narcotic use. Additionally, the note identified R27 was provided with supportive care and a safe	F 657	F657 Care Plan Timing and Revision o R27 has had care plan reviewed and revised to reflect needs for illicit drug use and unexpected leaves of absence o All residents care plans will be reviewed and revised with resident specific needs related to illicit drug use and unexpected leaves of absence o Education provided to LSW and IDT on care planning resident specific needs for those with active illicit drug use and/or unexpected leaves of absence to address interventions the staff may use to handle behaviors o Audit of the specific care planning and timely updates for illicit drug use and unexpected leaves of absence will occur two times weekly for 4 weeks then monthly for 2 months o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date 12/5/2018	

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F 657	Continued From page 60 environment. R27's Progress Note of 10/12/18 from the in house clinic psychologist identified R27 was found to have illicit substance use and episode of leave of absence (LOA). The note indicated collaboration with nursing and administration as to the importance of validation versus questioning interaction, awareness of impulsivity, and provision of support. The note additionally identified the potential safety risk to self and others. The Progress Notes of 10/12/18, at 2:02 p.m. indicated the facility implemented a resident check every two hours to assess mood state related to safety risks for resident and others. A review of the documentation indicates no expressed thoughts of intent to commit self harm or harm to others. A review of current care plan does not reflect a problem of R27 illicit drug use, and unanticipated LOA's, nor are there interventions to assist staff in handling these self destructive behaviors. On 10/16/18, 9:34 a.m. stated he had historically experienced feelings where he felt the desire to hurt either himself or hurt others but was not experiencing them now. R27 stated at those times, he left the facility for a while, going to the encampment (homeless camp), or rode the bus. On 10/18/18, at 10:48 a.m. the social service (SS)-A stated R27's records were reviewed and lacked additional information related to mood state and behavior. SS-A stated the MDS assessment and CAA information identified these areas of concerns and it should be addressed on	F 657		

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F 657	Continued From page 61 care plan. On 10/18/18, at 2:42 p.m. R27 stated while on leave on absence, he would often ride the train. R27 stated he has used meth, not crack, and has kept some "over" from his LOA's in the past but didn't have any at that time. On 10/19/18, at 8:57 a.m. registered nurse (RN)-A stated he was aware of R27's mood and behavior concerns, as well as his extended unplanned LOA and return to facility, and identified this information should be in his care plan. On 10/19/18, at 9:25 a.m. the administrator stated the record did not address R27's mood state, altered behavior, or potential use for illicit drug use in the care plan. Additionally, the care plan lacked a plan of action for the residents potential of harm to self or others. The administrator acknowledged this was important for staff to be aware of this. On 10/19/18, at 9:44 a.m. the director of nursing stated R27 has had an altered mood state and recent history of illicit drug use and this should be reflected in the care plan. The DON stated R27 is currently being followed by the in house psychologist for his concerns, and that also should be reflected in the care plan. A policy was requested for revision of comprehensive care plan but was not received.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process	F 660		12/5/18

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F 660	Continued From page 62 The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.	F 660		

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F 660	Continued From page 63 (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to facilitate and provide ongoing, comprehensive discharge planning for 2 of 2 residents (R29, R62) reviewed for discharge planning, and wished to leave the facility to a	F 660	F660 Discharge Planning Process o R29 has met with social services and discharge planning in progress o R62 no longer resides at the community	

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F 660	Continued From page 64 lower level of care. Findings include: R29's quarterly Minimum Data Set (MDS) dated 8/14/18, identified R29 did not have dementia or Alzheimer's disease, and was independent with his activities of daily living (ADLs) expect personal hygiene. Further, the MDS identified neither R29, family, or a guardian participated in the assessment; and there was no active discharge plan for R29 to return to the community. R29's care plan dated 2/23/18, identified R29 was a new admission and "plan is to [discharge] to new facility once his guardian is in place." The care plan described several interventions for this including a referral being out for guardianship and referring to CADI (Community Access for Disability Inclusion) for assessments and relocation work. Further, the care plan directed R29 had a history of chemical and alcohol abuse and appeared unable to make complex decisions without supervision. An intervention was listed on 2/15/18, which directed, "Resident to be referred to ACP [associated clinic of psychology] for mental health evaluation and neuropsych eval." During interview on 10/18/18, at 10:24 a.m. R29 stated he wished to discharge from the facility and go to a lower level of care environment, such as an apartment. R29 expressed he did not like living at the facility and did not need to be there since he was able to care for himself and had his cognition again adding, "I want to leave." R29 stated the facility staff were aware of his desires to leave, however, nothing had been done to help him leave thus far.	F 660	o All other residents discharge planning reviewed and assistance provided to follow up on action items as indicated to secure discharge. o Education provided to LSW and IDT on discharge planning o Audit of discharge planning will occur two times weekly for 4 weeks then monthly for 2 months. o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date 12/5/2018	

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R29's progress note(s) dated 2/9/18 to 10/16/18, identified the following entries:

On 2/9/18, R29 admitted to the nursing home from an acute care hospital.

On 2/15/18, the facility interdisciplinary team (IDT) identified R29 had a desire to leave the facility alone. "[R29] had called a cab this morning and wanted to leave to go to an apartment."

On 2/21/18, the licensed social worker (LSW) met with him as R29 continued to remove his wanderguard. LSW then, " ... went over his cognitive deficits with him and his pending neuropsych eval and possible outcomes for d/c [discharge] into the community." LSW communicated with R29's sister and dictated, " ... still trying to determine the level of cog deficits and as soon as we do we will be able to determine the best discharge location. Options include memory care or possible treatment."

On 4/11/18, LSW identified, "Provided additional information to ATTY [attorney] for guardianship proceedings. Today the neuropsych eval was completed." R29's corresponding NH Psych Testing note dated 4/11/18, identified R29 had a series of mental testing completed and listed a summary with several recommendations including a court-order guardian to assist with healthcare and finances and, "I recommend that he be discharged to a Group Home or Assisted Living Facility, assuming support from his Medical Team."

On 8/14/18, R29 was identified as, " ... noted entering a taxi cab after he had done the same

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thing yesterday evening." R29's appointed guardian was notified and, "In conclusion, is seems [sic] resident has a cognitive test coming up in the near future and will wait till [sic] that is concluded."

R29's Extended Care Nursing Home Visit note(s) since 4/11/18 were reviewed and identified the following:

On 6/4/18, R29 reported his health was good and expressed no medical concerns. R29 was dictated by the provider as having a cognitive impairment adding, " ... appears the patient may have had neuropsychiatric testing completed, though I am unable to locate the results. It appears guardianship is currently being pursued."

On 7/16/18, R29 was identified to have no health concerns reported by himself or nursing staff. R29 was again identified to have cognitive impairment with guidance directing, " ... had neuropsychologic testing completed on April 11th that revealed cognitive impairment, and a guardian was recommended. A group home of assisted living was also recommended, rather than independent living. We could consider repeat of neuropsychiatric testing again in October." Further, additional dictation identified R29 was a full code and, "Social Services is working on attempting to get a guardian in place for this patient."

On 8/13/18, R29 was seen and identified to have cognitive impairment with additional dictation directing, " ... had neuropsychologic testing completed on April 11th that revealed cognitive impairment, and a guardian was recommended. A group home of assisted living was also

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recommended rather than independent living. We could consider repeat of neuropsych testing again in October to look for improvement." Further, additional dictation identified R29 was a full code and, "Social Services is working on attempting to get a guardian in place for this patient."

On 10/15/18, R29 was seen and identified to have cognitive impairment with additional dictation directing, " ... had neuropsychologic testing completed on April 11th that revealed cognitive impairment and a guardian was recommended. A group home of assisted living was also recommended, rather than independent living. At some point, we could consider repeat of neuropsych testing to look for improvement." Further, additional dictation identified R29 was a full code and, "Social Services is working on attempting to get a guardian in place for this patient."

R29's medical record was reviewed and lacked any evidence additional neuropsychiatric testing had been ordered; nor evidence to demonstrate R29 had been assessed for potential discharge on an on-going basis despite a neuropsych evaluation being completed on 4/11/18, having a guardian appointed as directed by the examination and R29's care plan, and repeated dictations from R29's medical provider acknowledging R29's recommendations to have a setting with a lesser level of care.

During interview on 10/18/18, at 2:04 p.m. nursing assistant (NA)-F stated R29 did not require "much help" from staff to complete his cares. NA-F explained staff just provide him cues and reminders to do cares, such as oral care, and

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he walks without any assistance.

On 10/18/18, at 4:05 p.m. temporary licensed social worker (LSW)-A, registered nurse (RN)-A and RN-B were interviewed. LSW-A explained resident' discharge planning begins on "day one" of their stay. RN-A explained R29 had a pending Neurology appointment in November, which had to be rescheduled several times, and R29's daughter had expressed fear R29 would wander off so they were waiting for another cognitive test to be completed. RN-A acknowledged R29's medical record lacked any evidence a discharge plan was being pursued for R29 adding there wasn't a "concrete answer" for that. LSW-A stated she would facilitate the discharge conversation with R29 and implement a plan "going forward" though. RN-A added the lack of a consistent social worker had potentially "impeded this process." Further, LSW-A stated there was a scheduled visit for a neuropsychiatric examination for a different resident already scheduled to be complete at the facility and they would reach out and see if R29's could be completed then, too.

R62's diagnoses as identified on the Admission Record, printed 10/3/18, included chronic pain syndrome, flat back syndrome, acute, post-procedural pain and depression. R62's admission Minimum Data Set (MDS) dated 10/3/18, indicated R62 was admitted to the facility on 9/26/18 and was cognitively intact. Section "Q" of the MDS indicated R62 participated in the assessment, and there was no family or guardian participation. The MDS also indicated there was no active discharge plan in progress.

When interviewed on 10/15/18 at 3:22 p.m. R62

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stated she did not recall being formally involved regarding discharge planning. R62 stated the staff was willing go over and review your medications, but "not at all" the plan of care. There was been no discussion of what R62 wanted or liked. R62 complained that staff didn't follow through on things, and you had to initiate your concerns. R62 also stated it would probably take at least two days to "check out of here." R62 stated she was supposed to be leaving at noon on Wednesday (10/17/18), and needed home care but had no idea if that was happening. R62 stated she has a social worker from another county who called the facility "three times with no return call." R62 stated it was hard to talk to the social worker "if they're not in today."

A provider admission progress note dated 10/3/18, indicated R62 underwent extensive spinal fusion surgery, was transferred home, but returned to emergency department with additional complaints of pain, and subsequently transferred to nursing home for rehab. The note indicated R62 was participating in therapies.

During observation on 10/16/18 at 2:02 p.m., in the presence of the surveyor, licensed social worker (LSW) entered R62's room and began to tell R62 more details about tomorrow's (10/17/18) discharge. The LSW was very brief and simply stated she had home health case worker coming in to do in-home therapy, and they were waiting to get the orders for discharge. R62 looked at LSW and told her in a stern manner that she had until noon tomorrow "to get me out of here." The LSW told R62 she would have things ready, and emphasized to R62 she would still need the order for discharge from her physician, and then left R62's room.

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When interviewed on 10/17/18 at 12:41 p.m. the LSW stated this was her second day at the facility. The LSW stated R62's discharge was very resident driven and told us the day she was going home. The team had to determine if she had enough of her goals met so she could be discharged safely, which was completed. LSW let R62 know of the plans that were put together, and was not "fully aware" of how much and to what extent R62 was involved in the actual process of her discharge. The LSW stated "[R62] should have been included" in the planning process, and there should be documentation of what has been talked about, what was worked on, and the resident "should be fully informed to extent they can be" as to where they are as far as being discharged. The LSW reviewed R62's record and stated she "did not see much" in progress notes or other documents related to R62's plan to leave the facility.

When interviewed on 10/17/18 at 12:10 p.m. registered nurse (RN)-A stated the discharge process "of course" starts at admission, and acknowledged that R62's discharge planning "has been tenuous" because of our manpower situation. RN-A talked about the facility's issues with continuity of social workers, and how that person was key in setting up appointments, coordinating care conferences and keeping residents involved and updated on their discharge plan. RN-A stated he admits the new social worker at the facility likely had little knowledge of R62's discharge plans, and understood why R62 would feel "out of the loop."

R62's medical record and progress notes from 9/26/18 to 10/16/18 were reviewed and indicated

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F 660	Continued From page 71 there was only one one social services progress note, which also addressed R62's discharge. That progress note, dated 10/16/18, indicated: R62 would be discharging to home tomorrow; home care was arranged for physical therapy; R62 had arranged ; and that no further social service interventions were needed. R62's record lacked other forms, documents or other progress notes regarding R62's goals, plans or involvement in her discharge planning. When interviewed on 10/17/18 at 1:32 p.m. RN-B stated ideally the discharge process starts at admission, and in the case of (R62) we tried "as much as possible" to include her in the process. RN-B stated "I understand (R62) was not 100% involved." RN-B stated unfortunately we did not have a social worker for much of R62's stay here and R62 was in a rush to get out of the nursing home, and just yesterday "we initiated a lot of the paper work" for her discharge. RN-B stated it was really not the team's choice to have her discharge as soon as she wanted, and when the team realized she was going to be discharged, the team had to determine that she had progress enough and that it was safe for her to be discharged. RN-B stated usually we need to give the resident more heads up, and without a social worker, it's difficult. A facility provided Discharging a Resident policy dated 11/2016, identified the facility would develop and implement an effective discharge planning process which focused on the resident' goals and prepared the resident to be an active partner in discharging to post-discharge care. A procedure was listed which included several steps such as:	F 660		

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F 660	Continued From page 72 - "The IDT will review the discharge needs with each resident or resident representative. The discharge needs are identified and results in the development of a discharge plan for each resident," - "Regular re-evaluation of residents will be conducted to identify changes that require modification of the discharge plan. The discharge plan will be updated as needed to reflect these changes," and, - "The resident and resident representative will be included in the development of the discharge plan. The resident and resident representative will be informed of the final plan."	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is	F 661		12/5/18

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Continued From page 73

developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure an appropriate discharge summary had been completed for 1 of 1 residents (R66) who was discharged to home.

Findings include:

R66's Admission Record printed 4/18/18, indicated R66 was admitted to the facility on 4/6/17. Diagnoses included concussion with a loss of consciousness, along with several fractures and dislocation of spine related to a motor vehicle accident (MVA). Additionally, R66's diagnoses included. chronic pain, adjustment disorder with with mixed anxiety (A diagnosis which involves symptoms which are both emotional and behavioral., generalized muscle weakness and gait problems.

R66's discharge MDS of 7/30/18 indicated R66 had intact cognition and was independent with all cares.

R66's care plan was initially initiated on 4/20/17, and indicated R66 desired return to the community and requested housing assistance. The care plan was revised on 2/21/18 and indicated a referral to outside agency for an

F 661

F661 Discharge Summary
- o R66 discharged from the community
- o All other residents reviewed for discharge plan to ensure inclusion of discharging medications, teaching and recapitulation of stay
- o Education will be provided to IDT and licensed nurses on required components of discharge summary
- o Audits will be conducted 2 times weekly for four weeks then monthly for two months to ensure their oral care needs are being met
- o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed
- o Compliance date 12/5/2018

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assessment to receive services under Community Access for Disability Inclusion(CADI) waiver was made.

R66's Care Conference Summary completed on 6/27/18, indicated discharge was anticipated on 7/3/18. It was identified that resident was working on follow up visit with primary care physician and pharmacy.

R66's Progress Note of 6/27/18, indicated orders were received from primary care provider to initiate diabetic education which was to include glucose monitoring, appropriate insulin self dosing and administration. The progress notes of the primary care provider indicated R66 was to follow up in one month.

R66's Progress Note of 7/2/18, at 4:09 p.m. indicated diabetic education was given, however, the documentation failed to identify what information was provided, and the record lacked any written information to reflect this. The documentation indicated resident understood and self administered insulin following the proper procedure, however, the documentation lacked any areas of cares or prompts/cues required to complete task. The medication administration record (MAR) directed staff to "Initiate diabetic education for residents discharge. Teach glucose monitor and insulin administration. " The MAR indicated this was completed on all three shifts for the month of July , with only two shifts lacking documentation. The MAR notes, and the narrative Progress Notes do not indicate R66's understanding or performance of the tasks.

R66's Progress Note of 7/30/18, at 12:46 p.m. identified resident was discharged with his

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F 661	Continued From page 75	F 661		

clothes, personal property, and insulin. The documentation failed to indicate R66 was provided with discharge instructions, equipment provided, where to obtain equipment needed, or any medical follow up indicated. R66's record lacked additional forms or documentation with this information.

R66's Interdisciplinary Discharge Summary, signed by staff on 7/27/18, identified R66 was ambulatory short distances, but required the use of a wheelchair. The medication identified under the heading of Medication at Discharge identified R66 was to receive Humalog (insulin) 10 units (a measurement used to measure dosing) three times a day, and Basglar(insulin) 50 units at bedtime. The summary did not identify the frequency R66 was to monitor blood sugars with the use of monitor. The documentation lacked information regarding the symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) or what was to be done if either occurred. The summary lacked a recapitulation (summary) of R66's stay which included a summary of therapies received while at the nursing facility, diagnosis treated and interventions implement, lab work and x-rays completed, and any consultations which occurred. The documented also failed to reflect a reconciliation of all medications pre-discharge to those discharged with R66. The record also lacked post discharge instructions provided upon discharge, which should have included any indicated equipment, services, and follow up with provider.

On 10/18/18, at 9:37 a.m. registered nurse (RN)-A stated the original transfer papers had been given to the resident and a copy was not

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F 661	Continued From page 76 retained for the record. RN-A stated the narrative documentation does not reflect what was provided/reviewed with resident. RN-A stated the physician generally did the medication reconciliation and documentation of the above listed information was not consistently completed for residents upon discharge. RN-A stated there was not a narrative recapitulation of stay. On 10/19/18, at 10:29 a.m. the DON stated upon discharge from the facility it would be anticipated a copy of the discharge instructions would be reviewed with resident and a copy would be placed in the resident's record. The DON stated for R66 the discharge instruction should include diabetic management. The DON stated the discharge summary was to include the information which was needed to manage at home, however, did not generally include a pre and post discharge medication reconciliation and a recapitulation of stay. A facility policy Admission, Transfer, Discharge (General) revised 9/22/17, identified information to be provided upon transfer to an alternative provider would include the follow; history of present illness, reason for transfer and past medical history, contact information for provider and resident representative, advanced directive information, all special instructions or precautions, comprehensive care plan goals, and all any other documentation to ensure "a safe and effective transition of care."	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		12/5/18

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F 677	Continued From page 77 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine grooming and personal hygiene to 3 of 4 residents (R16, R34, R2) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R16's quarterly Minimum Data Set (MDS) dated 7/24/18, identified R16 had severe cognitive impairment and was totally dependent on staff for her personal hygiene. Further, R16's care plan dated 4/25/18, identified R16 required assistance with her ADLs and included an intervention for R16 which read, "A1 [assist of one] to shave PRN [as needed]." During observation on 10/15/18, at 2:34 p.m. R16 was laying in bed in her room with her eyes open, however, did not verbally respond. R16 had clearly visible, white colored facial hair present on her chin going down her neck. On 10/16/18, at 9:02 a.m. and 2:06 p.m. subsequent observations were made of R16. She continued to have visible, white colored facial hair on her chin and neck line. On 10/16/18, at 2:33 p.m. trained medication aide (TMA)-A was interviewed. R16 required total care from staff and "her aide" was responsible to ensure she was shaved. TMA-A observed R16 and stated her visible facial hair was "pitiful" and needed to be removed. TMA-A explained shaving should be completed when she received	F 677	F677 ADL Care Provided for Dependent Residents o R16 has had facial hair removed o R34 has had finger nails trimmed o R2 has received oral cares o All other dependent residents have been reviewed to determine their assistance needs for ADLs for facial hair, nail and oral care o Education provided to nursing staff on procedure for grooming and personal hygiene for dependent residents o Audits will be conducted two times weekly for four weeks and then weekly for two months to ensure ADL care is being delivered to dependent residents o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed o Compliance date 12/5/2018	

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her routine bathing, however, this should be removed anytime it is seen.

R16's Resident Body Audit dated 10/15/18, identified R16 received a shower. A series of questions were listed on the form for the staff to circle what cares and services were completed including, "Shaved (Men & Women) Yes No if no, why?" The staff member circled R16 was a female, along with "Yes," she had been shaved on 10/15/18.

When interviewed on 10/16/18, at 2:49 p.m. registered nurse (RN)-A stated residents' should be shaved with their routine baths. R16 was totally dependent on staff for her cares and she should have been shaved as it had been requested by family and for her own "personal grooming and hygiene."

R34's annual MDS dated 8/22/18, identified R34 was in a persistent vegetative state and was totally dependent on staff for their ADLs. Further, R34's care plan dated 4/25/18, identified R34 had an ADL self care deficit and listed a goal of, "[R34] will be clean and have ADL needs met by staff." The care plan listed several interventions to help R34 meet this goal including, "PERSONAL HYGIENE: I require total assistance with personal hygiene care. A1 including shaving," and, "Family chooses to cut nails and at times will cut them short and cut skin."

On 10/17/18, at 7:47 a.m. R34's morning care was observed with NA-E present. NA-E removed R34's bed sheet which exposed his (R34's) hands. R34 had visible, long fingernails present on each finger of both hands with some extending

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F 677	Continued From page 79 several millimeters (mm) in length. When interviewed on 10/17/18, at 8:03 a.m. NA-E stated R34 was a diabetic and "the nurses" should be helping him to clip his nails. NA-E observed R34's nails and stated they "need to be clipped." When interviewed on 10/17/18, at 8:16 a.m. licensed practical nurse (LPN)-D stated R34's nail care should be completed by the nurse as he is diabetic, adding nail care should be completed "as needed." LPN-D explained R34 got his blood sugar checked three times a day, however, there was no routine treatment or monitoring set up in R34's medical record to remind nurses' about completing his nail care on a routine basis. LPN-D observed R34's nails and stated she would trim them as he "can't do it for himself" and long nails could harbor bacteria. During interview on 10/17/18, at 1:07 p.m. registered nurse (RN)-A stated R34 was diabetic and the nurses are responsible to trim his nails. RN-A explained the family used to cut them, however, would sometimes cut them and cause bleeding, so he reiterated "it really is the nurses that should be cutting [them]." Further, RN-D stated R34's nails should be clipped and kept short as it was "just general hygiene." R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness) and was totally dependent on staff for their activities of daily living (ADL's). Conditions identified were a progressive cerebrovascular disorder caused by blocked arteries at the base of the brain and paralysis	F 677		

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F 677		F 677		

Continued From page 80

R2's care plan dated 4/25/18, identified R2 was totally dependent on staff for their oral care.

During observation on 10/17/18, at 9:06 a.m. nursing assistant (NA) -B and NA-F entered R2's room, announced aloud they were going to do morning cares. R2 was laying in bed. R2's body and washed, dried and lotion applied. NA-B and NA-F assisted R2 into her chair with use of mechanical lift. R2 has natural teeth. R2 did not receive oral cares from NA-B or NA-F. When interviewed immediately following the completion of morning cares NA-B stated the nurses are to complete R2's oral cares due to her having a trach with a potential for choking.

During observation 10/17/18, at 9:58 a.m. licensed practical nurse (LPN)-A administered R2's tube feeding. immediately after R2's tube feeding was completed LPN-A brought R2 to the day room. LPN-A did not complete R2's oral cares before bringing her out of the room. When interviewed immediately following observation LPN-A stated the nursing assistants were responsible for completing oral cares in the morning. There was no reason a nurse needed to complete R2's oral cares because "she is not a choking risk, they use a toothette" which uses minimal water.

When interviewed on 10/17/18, at 1:45 p.m. director of nursing (DON) stated the expectation is oral cares are expected to be completed every morning and evening and as needed. R2's oral cares were not to be completed by the nursing assistants but by a nurse as R2 had a trach and was at risk for choking.

A facility policy on personal hygiene and oral care

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F 677	Continued From page 81 was not provided.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and/or implement desired, meaningful activities for 2 of 3 residents (R2, R34) residents reviewed for activities. Findings include: R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness) and R2's activity section was not assessed related to R2 being in a persistent vegetative stated. Conditions identified were a progressive cerebrovascular disorder caused by blocked arteries at the base of the brain and paralysis. During interview on 10/15/18, at 6:59 p.m. family member (FM)-A stated she really wanted the facility staff to bring R2 to activities and did not want R2 laying in her bed waiting to die. The	F 679	F679 Activities meets the Interest/Needs for Each Resident o R2 has been comprehensively assess and implementations in place for meaningful activities o R34 has been comprehensively assess and implementations in place for meaningful activities o All other residents have been reviewed to determine their needs for meaningful activities o Education provided to activities staff on development of individualized activities plan of care to meet the needs of each resident o Nursing staff to have education on activities plan of care and their participation in implementation o Audits will be conducted two times weekly and weekly for 2 months to monitor meaningful activities	12/5/18

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facility staff report she is taken to the day room every other day for a couple of hours. R2 enjoyed R&B (rhythm and blues) music and only once in a year and a half had she visited R2 and she had any sort of music playing in her room.

R2's undated, Initial Activity Assessment identified R2 was admitted to the facility on 5/10/17, R2 was non-verbal and their religious preference was Baptist. The assessment had areas to document activity pursuit patterns including past and current interests, adjustment to placement, physical status, communication and cognitive patterns, attitude, special precautions/limitations/considerations and the source of the information obtained. These areas were all blank and not assessed. The assessment identified "unable to do assessment due to res [resident] cog [cognitive] and physical limitations family unavailable." There were no updates or attempts documented to complete a comprehensive assessment.

R2's care plan revised 1/12/18, identified R2 was limited in activity participation due to bed rest and physical and cognitive limitations. Interventions included: do assessment with family, provide 1:1 visits that work with R2's interest, provide calendar in room, involve family in activity interests and suggestions, hand massages, pet visits if able and read and put music on when in R2's room.

R2's care conference notes identified the following:

- On 10/26/17, the activity section identified R2 was a passive participant in activities, R2 had 1:1 activities and the facility would increase group

Provider's plan of correction (F 679):

implementation
o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed
o Compliance date 12/5/2018

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activities. However, the care conference notes did not identify what current 1:1 activities were being done or the frequency. Also the note did not identify what group activities R2 would attend and the frequency of the group activities.

- On 7/17/18, the activity section identified R2 received 1:1 activities and attended morning groups. R2 was a passive observer and tactile touch stimulation and reading was provided during 1:1s. The care conference note did not identify any further information..

- On 10/3/18, the activity section identified a statement of making sure R2 attended activities. There was no further information identified.

During observation on 10/16/18, at 10:11 a.m. R2 was lying in her bed, her eyes were open and the room was quiet without any music playing. At 2:02 p.m. R2 remained in bed, the room continued to be quiet without music. R2's lights were on in the room and the curtains were closed. No television or radio was seen in R2's room.

During interview on 10/16/18, at 3:02 p.m. nursing assistant (NA)-D stated R2 was already in bed for the evening shift when they arrived. R2 does not get up on the evening shift unless the nurses say to get her up. NA-D stated they have not seen anyone in her room reading , or any music playing. NA-D had not seen anyone provide activities to R2.

During interview on 10/17/18, at 9:06 a.m. NA-B stated R2 was assisted to her wheelchair one time on the day shift for no more than a few hours. R2 goes out to the day room, one time

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daily for no more then two hours, if there was an activity at that time she would be present. Otherwise she sits in the day room with whatever television program happens to be on. NA-B stated she did not see staff in the room reading to R2 and there was never any music on in her room. NA-F acknowledged the same.

During observation on 10/17/18, at 10:07 a.m. licensed practical nurse (LPN)-A wheeled R2 to the day room and placed her in the corner of the room facing the television. There was a morning news program on the television. R2 had no response to the television.

R2's activity attendance sheets for September 2018 through October 2018, were reviewed and identified the following:

- September 2018, R2 had seven 1:1 visits that consisted of reading or a sensory activity. It was not identified what was done during the 1:1's, how long they lasted and how R2 responded to them. Eleven times R2 was present at "Daily News"; however, R2's participation level was not identified. Pet therapy was offered four times but lacked R2's participation level. There was no documentation regarding R2's attendance at church. Daily television/radio was marked with a check.

- October 2018, R2 had five 1:1 visits that consisted of reading or a sensory activity. It was not identified what was done during the 1:1's, how long they lasted and how R2 responded to them. Nine times R2 was present at "Daily News"; however, R2's participation level was not identified Pet therapy was offered four times but lacked R2's participation level. It did not identify

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R2's church attendance. Daily television/radio was marked with a check.

During interview on 10/17/18, at 12:44 p.m. activities aide (AA)-A stated the activity director was responsible for completing the residents' activity assessments and care planning. The activity director was not at the facility and not available. R2's family had mentioned it was important for R2 to attend church on Sundays and staff were not getting R2 up timely and she had only been to church one time that month. AA-A stated she tried every other Monday to do hand massages with R2 alternating with reading a magazine to her. She was not aware R2 like R&B music and was under the impression family had placed an alarmed clock radio in R2's room that was programmed to come on. AA-A only put a check mark in the activity attendance sheet if R2 was present, she did not identify if R2 participated, observed, was passive or independent as the sheet identified to code activities as. She did check R2 was present daily for television/radio to account for R2's time in the day room with the television on.

During interview on 10/18/18, at 10:10 a.m. the facility administrator stated the activity director was currently not available as she was out of state. The administrator had not observed R2 in activities. Upon review of R2's Initial Activity Assessment, the administrator stated the activity director was responsible to complete a comprehensive assessment and multiple attempts with family should have been made to complete R2's assessment. It was important to know R2's likes and dislikes and have family input to appropriately plan activities for R2.

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A facility Activities policy dated 11/16 indicates "The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, care plan, and the preferences of each resident, an ongoing program to support residents in the choice of activities, both facility sponsored group and individual activities and independent activities, designed to met the interests of and support the physical, mental and psychological well being of each resident. "

CARE PLANNED ACTIVITIES NOT PROVIDED:

R34's annual MDS dated 8/22/18, identified R34 was in a persistent vegetative state and totally dependent on staff for their activities of daily living (ADLs).

R34's Activity Assessment dated 9/26/18, identified R34's socialization patterns. R34 was recorded as being "bed ridden" and rarely initiating conversations with a written intervention, "Has TV Hulu [and] Netflix for background noise." This intervention was selected with a checkmark demonstrating it was pertinent to R34's care for the assessment period.

R34's care plan dated 1/9/18, identified R34 had limited participation in activities due to physical limitations and poor cognition. A series of interventions were identified to help R34 meet his activity needs which included, "Resident has t.v [sic] in room, [family] request to have on for music and t.v [sic] programs for back ground noise."

On 10/15/18, at 2:20 p.m. R34 was laying in bed

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in his room with only his left eye open. A white colored Sony television set was on his dresser at the foot of his bed, however, it was not turned on, nor was any music playing in the room. Later, at 5:11 p.m. R34 remained laying in bed in his room and continued to have no television or music playing.

On 10/16/18, at 2:25 p.m. R34 was again laying in bed in his room. There was no music playing, nor was the television turned on to provide back ground noise as requested by the family.

Further, on 10/17/18, at 12:05 p.m. R34 was laying in bed in his room with no television or music playing to provide back ground noise as requested by the family.

On 10/17/18, at 12:31 p.m. nursing assistant (NA)-A observed R34 in bed with no music or television playing, and then inspected R34's television. NA-A explained R34 moved rooms the week prior and the cable must not have been hooked up yet as there weren't even cords for it in the room. NA-A stated it should have been communicated to maintenance so it could be installed so R34 didn't have to lay bed "all day without some form of entertainment."

When interviewed on 10/17/18, at 12:44 p.m. activities aide (AA)-A stated R34 used his television to watch and listen to religious programs which were important to him. AA-A explained the television was expected to be on during waking hours to help "make it more comfortable for him" in his room.

During interview on 10/17/18, at 1:10 p.m. registered nurse (RN)-A stated R34 changed

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F 679	Continued From page 88 rooms the week prior and it had not been "followed through" on to make sure his cable was connected to provide the desired music and television. RN-A explained R34 was unable to speak for himself and his family "enjoys him listening" to it so it should have been implemented. A facility provided Activities policy dated 11/2016, identified an individualized activity program for each resident would be developed and included on a resident' care plan. Further, "Activities staff, along with nursing and others, are to work together to ensure that the program is implemented."	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent comprehensive nursing care monitoring was completed for 1 of 1 resident (R63) for fluid overload who had congestive heart failure and pulmonary hypertension, and for 1 of 1 residents (R45) with essential hypertension. Findings include:	F 684	F684 – Quality of Care o R63 is receiving comprehensive nursing care and monitoring of fluid overload and CHF o R45 is receiving comprehensive nursing care and monitoring for essential hypertension o All other residents with CHF and HTN be reviewed to ensure appropriate	12/5/18

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R63's Progress Notes of 9/26/18, indicated R63 was alert and oriented and able to communicate her needs.

R63's Resident Information sheet dated 10/19/18 indicated R63 was admitted on 9/26/18 with the multiple diagnoses which included; pain in her right hip, chronic pain, acute respiratory failure, heart failure, anemia, and chronic obstructive pulmonary disease (COPD).

R63's discharge summary dated 9/26/18 identified R63's diagnoses to include asthma exacerbation (worsening), acute on chronic hypoxic respiratory failure (limited air movement through the body), pulmonary hypertension (A type of high blood pressure which affects the arteries in the lungs and the right side of your heart) and acute and chronic pain. The discharge identified R63 required use of oxygen continuously and nebulizer (process to administer medications to the lungs) therapy.

R63's care plan on updated on 10/3/18 identified R63's was at risk for nutritional status related to multiple medical diagnoses. Additionally the care plan identified R63 was a smoker and uses oxygen. There was no indication R63's care plan identified problems with respiratory status, pulmonary hypertension, heart failure, edema, pain management, or fluid overload related to congestive heart failure.

On 10/15/18, at 2:53 p.m. R63 was observed lying back on her bed, with her right leg hanging partially off of the bed. R63's legs were noted to be large in size and R63 voiced complaints about the pain and swelling in her legs and feet. R63's

F 684

interventions to provide comprehensive nursing care and monitoring
o Education provided to licensed nurses on monitoring for HTN and CHF, to include diuretic use, edema, labs, weights, and vitals
o Education provided to nursing staff on routine vital signs to include how often and necessary documentation.
o Audit for appropriate interventions to provide comprehensive nursing care and monitoring for CHF and HTN will be completed two times weekly for four weeks then monthly for 2 months
o DON/ Designee will report results and trends of all audits to QAPI Committee for review for 3 months and follow up as needed
o Compliance date 12/5/2018

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feet were notably swollen when R63 flexed her foot up in demonstration and was unable to fully flex. R63 used pursed lip breathing (A technique that helps people living with asthma or COPD when they experience shortness of breath), and was rubbing her legs and moving feet about, flexing and extending her legs.

The Progress Note of 10/17/18, at 4:25 a.m. indicated R63 complained of her lower extremities were hard and swollen, which was not normal. R63 called the emergency medical transport and was taken to the hospital. Prior to leaving for the hospital, R63's blood pressure was 120/83 and her pulse was 83. No additional assessment was identified in the record. The next narrative note of 10/18/18, at 6:58 a.m. indicated R63 was given Flexeril for muscle spasm and Atarax for itch. There was no indication when R63 returned from the hospital that a nursing assessment was completed that identified R63's vital signs, weight, lungs sounds, oxygen saturation or how much edema R63 had in her extremities. These areas are to be consistently monitored to identify residents who are are risk for fluid overload related to congestive heart failure, which is a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues. The next narrative note of 10/18/18 at 12:29 p.m. indicated R63 had no complaints of pain during the shift. There was no assessment or any monitoring of R63 vital signs, weight, oxygen saturation, lung sounds, and edema in her legs.

On 10/19/18, at 8:38 a.m. RN-A stated R63 returned the same day following the visit to the emergency room but this is not identified in the medical record. RN-A stated they should

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completed a comprehensive nursing assessment and monitoring of R63's condition when she returned from the emergency room and then ongoing monitoring of her condition related to pain. and edema of her lower extremities. Additionally, RN-A stated other assessments should have been completed, including a review of diuretic use, weights, vital signs and any lab work. RN-A stated these assessments were important related to R63's presenting symptoms in relation to her admission diagnosis of heart failure.

On 10/19/18, at 10:15 a.m. the DON stated an assessment and monitoring should be completed when a resident is transferred to and from the emergency room/hospital. Additionally, she would expect an ongoing assessment of the residnets needs, and monitoring of their clinical condition included vital signs, and follow up with the residents primary provider as indicated.

R45's annual MDS of 9/5/18, identified R45 had severe cognitive impairment and received extensive to total assistance with all aspect of personal cares including dressing, grooming, bathing and mobility. R45's medical diagnoses included: essential hypertension (high blood pressure doesn't have a known secondary cause), dementia, psychosis, and schizophrenia (Mental illness).

R45's care plan of 1/24/17 identified R45 was vulnerable as she was unable to communicate her needs and wishes or complete personal cares related to physical and cognitive limitations and dependent upon staff for her personal needs. R45 also has essential hypertension.

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F 684	Continued From page 92 On 10/15/18, at 7:21 p.m. R45 was observed in the day room, with the television on and the aviary present in the room. R45 was positioned facing the television in a semicircle with other resident's. R45 was observed to be sitting quietly, not verbalizing with others or responding to staff interaction. R45's next Progress Note on 8/31/18 included vital signs with a blood pressure reading of 110/76. The next monitoring was completed 6/4/18 which included vital signs recorded and blood pressure 126/80. The next recored blood pressure was on 3/9/18 and was 136/86. Although R45 had high blood pressure this was only monitored three times in the past seven months. On 10/18/18, at 12:24 p.m. nurse consultant (NC)-A stated she had inquired of the DON and identified narrative notes were not completed if there were no concerns identified but routine assessments were being completed. On 10/16/18, at 2:31 p.m. licensed practical nurse (LPN)-E stated vital signs are completed with according to the bathing schedule and if a bath is refused, they still get vital signs for monitoring the residents. On 10/16/18, at 3:44 p.m. the director of nursing stated vital signs should be checked routinely on bath days, and more frequently if indicated by the residents medical condition. The DON stated in R45's situation, it is especially important as she cannot tell staff what is going on with her, if she is in pain or if she is sick because she is non-verbal. The DON stated R45 has the diagnosis of	F 684		

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F 684	Continued From page 93 essential hypertension which is important to monitor. Skilled patients should be charted on every shift, and the long term patients should be charted as needed and with any change of condition, change in orders, new labs, or any communication with the physician or family members. The facility policy Vital Signs, Measuring Pulse, Respiration, and Blood Pressure dated 3/1/14 identified a resident's vital signs will be monitored routinely and/or as needed to note any abnormalities. The policy lacked definition as to what frequency "routinely" is and what process was to be implemented if abnormalities were noted. The facility policy Admission, Transfer and Discharge (General) dated 9/22/17 was received however, this lacked direction for assessment of resident status upon return from leave of absence against medical advice and how to assess following the return from hospitalization or an emergency visit.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	F689 Free from Accident	12/5/18

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F 689	Continued From page 94 review, the facility failed to ensure fall interventions were consistently implemented for 1 for 1 residents (R2) reviewed for falls. In addition, the facility failed to timely assess and document safe smoking abilities for 1 of 1 residents (R62) reviewed for accident hazards who smoked. Findings include: FALL INTERVENTIONS NOT IMPLEMENTED: R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness), had paralysis of all four limbs, and had a progressive cerebrovascular disorder caused by blocked arteries at the base of the brain and paralysis. The MDS identified R2 sustained two or more falls without injury since the last MDS was completed three months prior. R2s Fall Risk Assessment completed on 9/4/18, identified R2 had two falls in the last assessment period and was at high risk for falls related to a history of falls caused by sporadic high gag reflex with coughing. Further, R2s care plan revised on 7/11/2018, identified R2 used a custom ordered extended surface low bed with a perimeter defining mattress and directed staff to place R2's bed in the lowest position when occupied. Incident report dated 4/22/18, identified R2 was receiving cares, when turned to the side coughed violently, rolled out of bed sustained injury to left ear. Incident report dated 7/4/18, indicated R2 found on floor next to bed, sustained abrasion to right knee, laceration to face. During observation on 10/16/18, at 2:02 p.m. R2 was dressed and laying in bed. A perimeter mattress was in place on the bed, however, the bed was not in the lowest position as directed by the care plan. The bed surface was raised up from the floor approximately 12" to 15" (inches) in	F 689	Hazards/Supervision/Devices o R2 has her bed and fall mats in place per plan of care o R62 no longer resides at the community o All residents known to smoke have had comprehensive smoking assessment and intervention in place as indicated o All residents with recent falls will be reviewed to ensure appropriate interventions are in place to minimize/prevent injury o Education provided for IDT and nursing staff to ensure falls interventions are followed in accordance with the plan of care for each resident o Education provided to IDT and licensed nurses on requirement for timely assessment related to smoking o Audits to ensure falls interventions are in place will take place two times weekly for four weeks and then monthly for two months o Audits of falls interventions will occur 3 times weekly for 4 weeks and then monthly for 2 months o Audits of comprehensive smoking assessments will be done two times weekly for four weeks and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance Date 12/5/2018	

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F 689	Continued From page 95 height. At 3:02 p.m. (one hour later) nursing assistant (NA)-C entered R2's room and completed cares on R2. When completed, NA-C then lowered R2's bed to the floor with the frame resting on the floor and the surface of the bed parallel with the mattresses placed on the floor. When interviewed immediately following, NA-C verified the bed was not in low position when she entered R2's room, and stated R2's bed should always be placed into the lowest position when occupied. On 10/17/18, at 7:12 a.m. R2 was again laying in bed in her room. However, the bed was not in the lowest position, as demonstrated the day prior by NA-C, with the bed mattress surface being approximately 12"-15" from the floor. Further, the bedside mattresses placed to protect R2 from injury should a fall from bed occur were pushed back away from the bedside approximately 12 inches exposing the floor. At 7:19 a.m. the director of nursing (DON) entered R2's room and then left shortly afterwards, however, did not lower R2's bed down to the lowest position as directed by her care plan, nor did she reposition the bedside fall mattress. At 7:36 a.m. (14 minutes after observation began), licensed practical nurse (LPN)-A entered R2's room, and at 7:37 a.m. registered nurse (RN)-B entered R2's room. However, neither LPN-A or RN-B lowered R2's bed into the lowest position, nor repositioned the bedside fall mattress to protect R2 in the event of a fall. During interview on 10/17/18, at 8:05 a.m. LPN-A stated R2's bed should be all the way on the floor with mats against the bed. Further, when interviewed on 10/17/18, at 9:06 a.m. NA-F stated the bed needs to be down flat on the floor when occupied and staff are not completing cares. When interviewed on 10/17/18, at 1:45 p.m. the	F 689		

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DON stated there had been a problem with the bed not always being kept in the lowest position when occupied. R2 used a custom bed which would allow it to be lowered very close to the floor, and the expectation was for staff to ensure it's kept in the low position when occupied to minimize injury, and prevent serious injury, should R2 have a coughing episode and falls from the bed.
A provided Accidents/Falls - HDGR policy dated 2/2014, identified the facility strived to provide residents' an environment " ... that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents." Further, a procedure was listed which directed resident care plans' should be evaluated and updated quarterly and/or with significant changes, and, "Documentation of the risks and interventions, with the focus on prevention and maintaining a safe environment, should be made."
LACK OF A SAFE SMOKING ASSESSMENT

R62's diagnoses as identified on the Admission Record, printed 10/3/18, included chronic pain syndrome, flat back syndrome, acute, post-procedural pain and depression. The MDS indicated R62 had no upper extremity impairments, and also had intact cognition. The MDS indicated R62 was admitted to the facility on 9/26/18.

During observation on 10/16/18 at 2:15 p.m. R62 was seated and propelling self in her wheel chair through the main dining area toward an door, leading to an outside patio. R62 told nursing assistant (NA)-I she wished to smoke, and NA-I opened the door, and R62 entered the outdoor

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patio. Once outside, R62 pulled with her finger, a cigarette from an opened cigarette pack she had on her person, and placed it in her mouth. R62 then reached in seat of the wheel chair and produced a lighter, and lit the cigarette independently. As she smoked, R62 held the cigarette either in her mouth or between the fingers on her right hand, and intermittently ashed the cigarette; R62 did not ash on herself. R62's did not have burn holes. R62 did not finished the entire cigarette, but extinguished it in the upright ash container in the patio, then dropped the remaining butt in the container. R62 then re-entered the building.

During interview on 10/16/18 at 2:29 p.m. R62 stated she smoked while at the facility. R62 stated she could smoke when she wanted, held her cigarettes on her person, and was able to light, smoke and get rid of the cigarette without anybody's help. R62 stated she could independently.

When interviewed on 10/16/18 at 2:33 p.m. nursing assistant (NA)-I stated R62 did not go out to smoke too often, and R62 "was able to do so on her own." NA-I stated R62 was out in the patio just out a few minutes ago, smoking.

On 10/16/18 at 2:50 p.m. R62 assessments, both in the paper chart and electronically, were reviewed. The medical record lacked any assessment regarding R62's safe smoking abilities.

During interview on 10/16/18 at 3:59 p.m. registered nurse (RN)-B stated R62 was an independent smoker. RN-B searched in both electronic and paper record but was unable to

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F 689	Continued From page 98 find any smoking assessment for R62. Subsequently on 10/17/18 at 1:25 p.m. RN-B stated he was certain R62 was reviewed for safe smoking, but stated he could not find a record of that. RN-B stated "I know that is incomplete documentation." During interview on 10/18/18 at 10:50 a.m., the director of nursing (DON) stated R62 did not initially indicate she was a smoker upon admission, and a determination about whether a resident is safe to smoke was part of the admission process. The DON stated she thought R62 was observed and was "ok" to smoke independently. The DON stated if it was not completed, "a smoking assessment should have been done for (R62)." A facility document, Smoking Policy, effective 10/11/18, indicated it was the facility policy to provide a safe environment for all residents. The policy directed all residents who smoke will be assessed for their safety at time of admission, quarterly and when there is a change in condition..." Further, the smoking assessment would include physical, cognitive mood and behavior that may affect their ability to smoke without supervision.	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 ensure that a resident-	F 693		12/5/18

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F 693	Continued From page 99 §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 document review, the facility failed to ensure appropriate interventions were taken to reduce the risk of aspiration for 1 of 1 residents (R34) reviewed who used a tube feeding and was observed to be positioned flat in bed while their feeding was running. Findings include: R34's annual Minimum Data Set (MDS) dated 8/22/18, identified R34 was in a persistent vegetative state and was totally dependent on staff for their activities of daily living (ADLs). Further, R34 received 51% or more of their nutrition through a tube feeding. R34's Physician's Orders signed 7/11/18, identified R34 was to have nothing by mouth (NPO) and used Nepro with Carb Steady feeding through a jejunostomy (J-Tube) at 45 cubic centimeters (cc) an hour continuously for 20	F 693	F693 Tube Feeding Mgmt/Restore Eating Skills o R34 has received tube feeding while in the proper positioning o All other residents needing tube feeding will be reviewed to determine bed positioning needs while feeding is running o Education provided to nursing staff on the need to elevate HOB during tube feeding o Audits for necessary elevation of HOB during tube feeding will be done two times weekly for four weeks then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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hours a day. Further, an additional signed order directed, "Keep head of bed >(over) 30 to 45 degrees or in reverse Trendelenberg during feeding and for 30 minutes after feeding." In addition, R34's care plan dated 11/10/17, identified R34 had a tube feeding in place related to dysphagia (difficulty swallowing) and listed several interventions for R34 including, " ... need the [head of bed] elevated 45 degrees during and thirty minutes after tube feed."

During observation on 10/16/18, at 2:25 p.m. R34 was laying in bed in his room. R34's tube feeding was running with a visible tube connected to his abdomen, however, the head of R34's bed was not elevated and was flat, with R34's head being elevated with only pillows. At 3:11 p.m. (over 50 minutes later) R34 remained in bed with his tube feeding running and the head of the bed not elevated.

At 3:14 p.m. the surveyor notified licensed practical nurse (LPN)-C regarding R34 laying in bed with his tube feeding running. LPN-C observed R34 in bed with the head of the bed flat and stated it should not be flat when the tube feeding is running as "he could aspirate." LPN-C added the head of the bed should be "at least 45 degrees" elevated when R34 was receiving his tube feeding.

When interviewed on 10/17/18, at 1:05 p.m. registered nurse (RN)-A stated R34 used a tube feeding and the head of the bed should be raised up 30-45 degrees while the feeding was running to reduce the "risk of aspiration."

A facility provided Gastrostomy Tube Feeding - Bolus policy dated 4/2009, identified a patient

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F 693	Continued From page 101 should be in "semi-fowlers position (on back with head of bed raised)" for feedings.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure tracheotomy suctioning was provided in accordance with acceptable standards of practice to prevent potential complications for 1 of 2 residents (R34) reviewed for respiratory care and services. Findings include: An undated John Hopkins Medicine "Suctioning" feature identified the human upper airway warms and cleans the air we breathe; however, with a tracheotomy (incision in the windpipe making a direct airway in the trachea) the air is cooler and drier which causes increased mucous production which can be removed with suctioning the tracheotomy. A procedure to suction a tracheotomy was listed which directed several steps including: - Positioning the patient in bed or a chair,	F 695	F695 Respiratory/Tracheostomy Care and Suctioning o R34 has been receiving suctioning per standards of practice o All other residents needing tracheostomy suctioning will be assessed to determine needs for suctioning if indicated o Education provided to licensed nurses on the need to provide suctioning within the standards of practice to prevent potential complications o Audits for procedure of tracheostomy suctioning will be done two times weekly for four weeks then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	12/5/18

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- Wetting the suction catheter with sterile and/or distilled water for lubrication before inserting into the patient airway,

- Removing the tracheotomy inner cannula from the outer tracheotomy tube; and,

- Carefully inserting the suction catheter in the tracheotomy tube, then placing your thumb over the suction vent intermittently while the catheter is removed.

R34's annual Minimum Data Set (MDS) dated 8/22/18, identified R34 had respiratory failure and received tracheotomy care and suctioning while a resident in the facility. Further, R34's care plan dated 10/16/18, identified R34 had a tracheotomy in place and listed several interventions including, "Suction as necessary."

On 10/18/18, at 9:22 a.m. tracheotomy suctioning was observed. Licensed practical nurse (LPN)-B positioned R34 in a reclining geri-chair and opened a sterile set of supplies including a 14 Fr (French) suction catheter. LPN-B attached the suction catheter to a suction machine and stated aloud to R34, "Time to suction you, OK?" and inserted the suction catheter into R34's tracheotomy with her thumb applied to the suction vent of the catheter, creating suction. LPN-B did not lubricate the catheter, remove the inner cannula, nor wait to apply suction before inserting the suction catheter into R34's tracheotomy. Further, no oxygenation equipment (i.e. pulse oximeter) was connected to R34 to ensure adequate respiratory status during the procedure.

LPN-B removed the catheter and placed the tip into the set-up sterile water on the bedside table,

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then re-inserted it again into R34's tracheotomy while applying suction saying aloud she was "not getting nothing." LPN-B removed and then re-inserted the suction catheter for a third time which cause R34 to lean forward and his eyes to open widely while coughing with visible yellow tinged secretions being removed inside the suction catheter. LPN-B then turned to the surveyor and stated, "I'm done," before removing her gloves and cleaning up the supplies.

On 10/18/18, at 9:47 a.m. LPN-B was interviewed about R34's tracheotomy suctioning. When questioned about not having any oxygenation monitoring (i.e. SpO2), not lubricating the catheter before inserting it into R34's stoma, the lack of removing the inner cannula, and applying suction before the catheter was inserted into the tracheotomy, LPN-B did not respond with a reason, but stated aloud, "I don't know what to say." LPN-B added she had received training through the facility on how to care for tracheotomy patients; however, felt maybe she made errors when observed due to "nervousness."

When interviewed on 10/18/18, at 10:29 a.m. registered nurse (RN)-A stated tracheotomy suctioning should include monitoring the patient's oxygenation during and after the cares were performed, lubricating the catheter before inserting it, and not applying suction pressure to the catheter until removing it so as to help avoid "oxygenation issues." RN-A explained leaving the inner cannula in place was better for the patient to avoid tissue damage, however, added the staff "need some education" on providing tracheotomy care.

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F 695	Continued From page 104 A facility Tracheotomy Suctioning policy dated 12/2013, identified a procedure to be followed which included lubricating the tip of the catheter with saline before inserting it into a patients' stoma, and, "...without applying suction, insert suction catheter about 3 inches or until client coughs." The policy lacked any information on how or if the patient should be monitored for oxygenation during the procedure, nor if the inner cannula should be removed for tracheotomy suctioning.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to reduce pain for 2 of 2 residents (R8 and R52) who had expressed, and were observed, with concerns about pain management. Findings include: R8's quarterly minimum data set (MDS) of 7/10/18, identified R8 had intact cognition and received extensive assistance of staff to complete activities of daily living (ADL's) including dressing, grooming, bathing, and mobility. R8's medical diagnoses includes peripheral vascular disease (PVD- A disease when there is restricted blood	F 697	F697 Pain Management o R8 has had comprehensive pain assessment and interventions updated as indicated o R52- is not identified on the resident sample list provided to the facility o R2 has had comprehensive pain assessments and interventions updated as indicated o All resident□s pain assessments will be reviewed and care plan updated as indicated o Pain assessment has been reviewed and updated as indicated o Licensed nurses will be educated on comprehensive pain assessment and	12/5/18

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F 697	Continued From page 105 flow to the limbs. Symptoms usually affect the legs, causing pain, cramps), diabetes mellitus, history of a hip fracture, chronic pain, amputation of limb, and localized swelling of upper limb with muscle weakness. The MDS indicated R8 experienced pain frequently with pain described as moderate. The MDS indicated R8 received routine and intermittent (PRN) medication, but indicated R8 lacked non-medication interventions. R8's care plan revised on 2/4/18, indicated R8 had a chronic physical disability and pain related to a left below the knee amputation (BKA). The care plan also identified R8 received pain medication therapy. The care plan directed staff to evaluate the effectiveness of pain interventions and to assess if the level of pain was acceptable to resident. Additionally, the staff were to assess for the impact of pain on R8's functional abilities. R8's care plan also identified R8 had the diagnosis had the diagnosis of PVD and the interventions directed staff to monitor for edema and signs and symptoms of pain. Staff were encouraged to encourage R8 to elevate his legs. The care plan does not identify any interventions which are not related to the administration of medications, with the exception of encouraging resident to elevate his legs. The care plan did not identify use of alternate therapies such as application of heat or ice, repositioning, massage, or diversion therapy or if they had been tried historically without success. On 10/15/18, 6:28 p.m. R8 is observed at this time, laying back against his bed with the head of the bed elevated. R8 stated he wanted to receive a cortisone injection and had spoken with the nurse practitioner, head nurse, and the medication nurses without success. R8	F 697	include non-pharmalogic interventions for pain o Audits will be conducted two times weekly for four weeks then monthly for two months to ensure pain is comprehensively assessed and non-pharmologic interventions are in place o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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described his pain as terrible and his left shoulder as "real bad.". R8 also stated he had low back pain and problems with his right shoulder. R8 stated he had multiple injuries in his past which have impacted both shoulders and lower back. R8 stated he has had injections in the past but has not had one recently. R8 stated he had medications ordered for pain routinely and also as needed (PRN). R8 stated he uses an electric wheelchair for mobility related to his difficulties with his shoulders.

R8's Admit/Readmit Assessment completed on 4/26/18, identified R8's pain level at "8" and was described as severe. The pain was described as sharp, which was triggered with movement, however, movement also helped to improve pain level. The assessment indicated R8's pain did impact his sleep and he often remained in his room related to his level of pain. A Pain Data Collection and Assessment completed on signed 5/10/18 indicated pain described by R8 as aching, throbbing, and shooting and location was noted as the sacrum and the left shoulder. The assessment identified R8's goal was a score of 1 on a scale of 0 to 10. Symptoms of pain observed by registered nurse (RN)-A with assessment included moaning/groaning, grunting and screaming. R8's Pain Data Collection and Assessment dated 10/9/18 indicated R8 receives MS contin 15 mg every 12 hours and oxycodone 5 mg by mouth every four hours as needed for bilateral shoulder and chronic back pain. No additional interventions were identified.

R8's Progress Notes of 5/7/18 identified upon reviewing dictation following the provider visit of 5/2/18, an order was placed for an appointment with Interventional Radiology for left shoulder

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injection. A review of subsequent Progress Notes lacked indication this appointment was scheduled or completed.

A review of physician progress notes of 8/1/18 identified R8 had historically received a shoulder inject with some improvement. An order was written for an ortho consult to see if there were any options for the shoulder. A subsequent note of 9/26/18 indicated R8 had reported increased shoulder pain which had significantly decreased his functional abilities. A subsequent order was again written for ortho consult and injection of the left shoulder.

R8's Physician's Order sheets signed by provider on 10/3/18, identified R8 listed the following orders in place for pain management; Oxycodone Immediate 5 mg every four hours as needed, acetaminophen 325 mg two tablets every four hours while awake (Not to exceed 4000 mg (milligrams-unit of measurement) in 24 hours), Baclofen 10 mg by mouth three times daily for spasm, Diclofenac sodium 1% gel to left shoulder twice a day for pain, Gabapentin 600 mg tablet by mouth three times a day for chronic back pain, morphine sulfate ER (Extended release) one tablet every 12 hours for pain, and Lexapro 5 mg one half tab daily.

A review of R8's medication sheets for the month of August identified R8 had received the Oxycodone on 46 occasions. R8's medication sheet of September indicated use of Oxycodone on 34 occasions, and from October 1-19, 2018 he had received it on 24 occasions.

A review of the Progress Notes identified R8 generally identified his level at an 8 on a scale of

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0-10. R8 had previously expressed his goal for pain management was a score of 1.

On 10/18/18, at 3:53 p.m. the health unit coordinator (HUC)-A stated R8 had gone in for consultation previously at the hospital for his shoulder but they were unable to treat related to his size and inability to complete in the procedure room. HUC-A stated she was unaware of any subsequent follow up ordered or recommended as the procedure was not completed. HUC-A stated she was unaware of any current orders for this.

On 10/19/18, at 8:50 a.m. RN-A stated he was unaware of any physician orders or recommendations for an ortho consult or cortisone injections of R8's shoulder. RN-A stated if this was reviewed by the physician during their visit, it should have been coordinated for resident.

On 10/19/18, at 10:15 a.m. the director of nursing stated she recalled in the past there had been some difficulty with coordinating an injection for R8, however, was unable to provide documentation via narrative notes or schedules. The DON stated she recalled difficulties related to R8's size but was unable to recall specifics. The DON stated if a referral was ordered and not completed, there should be documentation to reflect this in the record. Further, the DON stated interventions implemented for R8 should be indicated in the care plan.

A policy was requested for review of physician progress notes and follow through on recommendations but was not received.

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R2's Annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness). Conditions identified a progressive cerebrovascular disorder caused by blocked arteries at the base of the brain and paralysis. R2 received scheduled pain medication and did not identify R2 received as needed medication or non pharmacological interventions. The MDS pain assessment was not completed related to R2 being in a persist vegetative state.

During interview on 10/15/18, at 7:19 p.m. family member (FM)-A stated R2 had pain and was supposed to be on morphine (narcotic medication to manage pain) as she cried whenever she was touched.

R2's Pain Data Collection and Assessment HDGR dated 9/24/18, identified R2 had facial grimacing, teary eyes and no verbalization of pain. The assessment did not identify medications or any non-pharmacological interventions to relieve pain or a diagnosis for the potential pain. The summary section of the pain collection tool provided a check only option identifying if the resident exhibited pain or not. R2's was identified that she exhibited signs and or symptoms of pain. The collection tool did not identify a comprehensive analysis of R2's pain.

R2's physician orders signed 10/3/18, identified the following pain medications:
- acetaminophen 650 milligrams (mg) every 6 hours as needed for pain
- morphine 20 mg/5 milliliters (ml) give 0.5 ml every 8 hours.

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R2's care plan dated revised 4/24/18, identified R2 had a potential for pain related to physical conditions. Interventions included the following: administer pain medications as ordered, anticipate need for pain relief and respond immediately to any signs of pain, observe for/record/report to nurse any signs of symptoms of non-verbal pain.

During observation on 10/16/18, at 2:02 p.m. R2 was laying in bed with eyes closed, no non-verbal signs of pain displayed.

When interviewed on 10/16/18, at 3:02 p.m. nursing assistant (NA)-C stated the only time R2 showed any pain was when the staff repositioned her, which happened daily. When R2 was displayed signs of pain the staff stop and try and calm her by holding her hand and telling her everything was ok. The staff felt R2 was having pain when she opened her mouth wide.

On 10/17/18, at 7:12 a.m. R2 was laying in bed, with her eyes closed and did not display any non-verbal signs of pain

When interviewed on 10/17/18, at 8:32 a.m. licensed practical nurse (LPN)-A stated R2 "cried" when the nurse suctioned her trach and when the staff moved her. LPN-A stated she viewed R2 as crying because her face changed by opening her mouth wide. LPN-A stated she felt R2's "crying" was less when she received her scheduled pain medications.

During observation on 10/17/18, at 9:06 a.m. NA-B and NA-F entered room to provide morning cares. R2 was laying in bed, and displayed no non-verbal signs of pain. R2's mouth opened

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F 697	Continued From page 111 wide, similar to a large yawn, without tears when NA-B and NA-F moved her arms and legs. R2 closed her mouth as soon as NA-B and NA-F stopped moving R2. R2 did not display the wide yawn during other touching, only when physically moving R2's limbs and body. When interviewed immediately following NA-F stated R2 "cried"out when cares were being done, every time she was moved or touched. NA-F described R2's "crying" as, she opened her mouth wide. During interview on 10/17/18, at 1:45 p.m. director of nursing (DON) stated R2 grimaces and looks like she is in pain with cares and any movement; however, did not believe she was having pain, but rather an involuntary reflex of movement. R2 was on scheduled pain medication, in case she was having pain, the facility could not assess for. When interviewed on 10/19/18, at 9:00 a.m. registered nurse (RN)-D stated nurses should assess for pain when R2 was lying down, up in her her chair, and when being moved around. This helped to get a complete view of her pain. R2 grimaced when being moved and repositioned and felt R2 had displayed signs of pain. During interview on 10/19/18, at 9:02 a.m. facility medical director (MD) stated R2 had a disease process which made if very difficult to assess for pain. R2 had been on higher and more frequent doses of pain medication, which caused R2 to have difficulty breathing. Upon reducing R2's pain medications there had not been a change in the yawn, that the staff believes was a non-verbal sign of pain. MD did not believe R2 had much	F 697		

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F 697	Continued From page 112 actual pain and felt the yawn was not a cry , but rather an involuntary reflex. She remained on scheduled pain medication just in case R2 was experiencing any pain. When interviewed on 10/19/18, at 9:27 a.m. RN-A stated R2 had not been comprehensively assessed by the nursing staff for pain. The Pain Data Collection and Assessment HDGR dated 9/24/18, was only a tool they used for pain. The tool did not include an analysis or plan for R2's pain management. RN-A identified a comprehensive pain assessment should be completed to identify any changes, what causes the pain, if R2 was truly having pain and what helps and would assist in implementing the appropriate pain interventions. A facility policy Pain Management dated 11/16 indicated this process was in place to identify, monitor and evaluate pain. The procedure identified staff were to determine appropriate interventions such as relaxation, heat, cold, massage, positioning and distraction which may be used to supplement pharmacological interventions.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 698	F698 Dialysis	12/5/18

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review, the facility failed obtain and record vital signs and ensure post-dialysis records were consistently received for 1 of 1 clients (R38) reviewed for dialysis.

Findings include:

R38's diagnoses, as identified on the quarterly Minimum Data Set (MDS) dated 7/23/18, included end stage renal disease, hypertension and type 2 diabetes. The MDS also indicated R38 had intact cognition. R38's care plan, revised 5/24/18, identified R38's need for hemodialysis related to end-stage renal disease, and had a goal to have no signs or symptoms of complications from dialysis through the review date. R38's care plan directed staff to encourage R38 to go for the scheduled dialysis appointments, and monitor labs and report to doctor as needed.

During observation on 10/17/18 at 8:24 a.m. R38 was seated in the dining room, dressed for the day, and receiving the breakfast meal tray, which included a bowl of hot oatmeal, two slices of wheat toast, two hard boiled eggs, singe-serving sized peanut butter and strawberry jam packages, and small cup of apple juice and mug of coffee. When R38 received the breakfast meal tray, dietary staff told R38 she would have a lunch to take to dialysis ready. R38 independently opened the peanut butter package, and spread it on the toast, and began to consume her breakfast. R38 ate without assistance. Later at 10:02 a.m., R38 was observed seated on a Metro Mobility bus, parked just outside the facility entrance.

A physician's order dated 10/11/18 directed staff to obtain vital signs every Tuesday and Thursday,

F 698

o R38 has had Vital signs obtained per orders from provider
o R38 has had dialysis records obtained from dialysis center
o All residents receiving dialysis reviewed and communication between dialysis and community established
o Licensed nurses will be educated on need for monitoring and obtaining dialysis communication for collaboration of care
o Audits will be conducted two times weekly for four weeks then monthly for two months to ensure pain is assessed and treatment plans are updated.
o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed.
o Compliance date 12/5/2018

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and to include temperature and O2 (oxygen) saturation; to obtain vital signs (blood pressure, temperature, pulse, respirations) upon return from dialysis on Monday, Wednesday and Friday; to please ensure post dialysis note is placed in chart; and to ensure vital signs readings in PCC (Point Click Care) [the facility's electronic heath record system.]

When interviewed on 10/17/18 at 10:10 a.m. licensed practical nurse (LPN)-A stated she did not take R38's vital signs prior to dialysis, but did take vital signs upon R38's return from her dialysis runs. LPN-A stated she would assess R38 after dialysis, check her access site for bleeding, and listen for bruit (the audible, vascular flow of blood hear through a stethoscope). LPN-A stated she normally took R38's blood pressure when she came back from dialysis, but would not document the blood pressure," unless they (the blood pressures and vital signs) were not normal," at which time "I would then notify the doctor." LPN-A said vital signs typically meant temperature, pulse, respirations and a blood pressure, and stated R38's vitals were taken frequently during the dialysis, and came back on a report. LPN-A stated the dialysis center would send a report with R38 which had information and anything new about her dialysis that day. LPN-A stated the on-duty nurse would be responsible to assess R38 and note any irregularities when she came back from dialysis. LPN-A stated she did not know who was responsible to make sure the run sheet was placed in R38's chart, so there was consistent communication with dialysis.

A review of R38's electronic health record (EHR) for vital signs from 10/12/18 to 10/18/18 indicated there were no vital signs recorded. The EHR

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lacked any record of temperature, pulse, respirations, blood pressure or oxygen saturation during these dates. A review of the EHR since R38's most recent re-admission to the facility on 8/28/18, indicated blood pressures were recorded on 8/28/18 (twice); 9/1/18/, 9/14/18, 9/22/18, and 9/23/18. R38's EHR contained no more recent documentation of blood pressures or other vital signs.

R38's medication administration records (MAR) and treatment administration record (TAR) for October 2018 in the paper chart were reviewed, and lacked any recording of blood pressures or any vital signs. R38's record lacked any recording of the ordered vital signs as directed by the provider order dated 10/12/18. Neither the MAR nor TAR for October 2018 had R38's temperature, pulse, respiration, oxygen saturation or blood pressures recorded.

R38's medical record contained "Post Treatment" reports, a multi-page, machine-generated document which detailed R38's dialysis treatment for a specific day. The report provided details for a daily run, which included: date of run, prescription information, machine set up, various pre and post treatment data, volume of fluid removed and blood flow rates, and vital signs at various times during dialysis treatment. R38's medical record contained Post Treatment reports for the following dates in October: 10/1/18, 10/3/18, and 10/12/18. R38's chart lacked any more current reports to ensure consistent communication with dialysis.

When interviewed on 10/18/18 at 1:34 p.m. registered nurse (RN)-A stated R38 "typically" came back with communication from dialysis,

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which is to be reviewed by the floor nurse. RN-A stated R38 should be assessed when she comes back after dialysis, and also R38 also had an order to do blood pressures on Tuesday and Thursdays, when she does not go to dialysis. RN-A stated all vital signs "should be recorded in the MAR" (medication administration record). RN-A stated he thought the provider order (that the post dialysis note be placed in chart) was written "to make sure it gets in the chart." RN-A stated he expected R38 be assessed after she came back to the facility, and to monitor any unusual report or finding that occurred during dialysis.

During interview on 10/18/18 at 3:54 p.m. the director of nursing (DON) stated vital signs should be done when a resident returns from their dialysis. The DON stated R38's dialysis provider did send a dialysis run report daily, and that report "should be given to nursing, reviewed," and also that report "should be filed in (R38's) chart. The DON also stated if there is an order for specific vital sign, "then we should be doing that."

When interviewed on 10/19/18 at 9:15 a.m. the dialysis patient care technician (PCT) stated after each of R38's runs at the dialysis center, a post-run report was generated. The PCT stated the report contains "a full history" of the run, including things like vital signs, the amount of fluid pulled of during the run, and noted any issues would be noted. the PCT stated the post dialysis report was sent along with R38 "all the time" and if it got missed, we make sure to fax the report the same day. The PCT stated there is "always access to the report."

During interview on 10/19/18 at 9:30 a.m. the

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F 698	Continued From page 117 medical director (MD) stated because R38 was on dialysis, she had many opportunities for monitoring vital signs and blood pressures. The MD stated he "would expect" physician's orders be followed and staff needed to obtain and record blood pressures and vital signs, and also that the post-dialysis run reports be included in R38's chart, so there was consistent communication from dialysis. A facility Clinical Records (General) policy, revised 3/1/2014, directed the records should be maintained "in accordance with accepted professional standards and practice," including complete, systematically organized, accurately documented and readily accessible.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		12/5/18

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F 700	Continued From page 118 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure affixed bed rails were maintained in a safe, secured manner to prevent entrapment and/or accidents for 1 of 1 residents (R63) observed with a loose bed rail. Findings include: R63's Progress Notes of 9/26/18, indicated R63 was alert and oriented and able to communicate her needs. R63's admission Minimum Data Set (MDS) lacked assessment of cognition, but indicated no symptoms of delirium. The MDS indicated R63 was independent with bed mobility, transfers and required supervision to walk. R63 was identified as being independent with dressing and requiring extensive assistance with personal grooming. R63's medical diagnoses included asthma, acute respiratory failure, cardiovascular accident (CVA-stroke), and heart failure. On 10/15/18, at 2:59 p.m. R63 stated her right side rail was loose, and demonstrated this by shaking rail with her hand. The left rail was securely affixed to the bed and was positioned against the wall, non exit side of bed. The right side rail was loose when wiggled back and forth and moved away from the bed at a distance of approximately eight inches from the edge of the mattress. R63 stated she was concerned the rail may come loose and fall/break off causing an accident. R63 was independent with transferring	F 700	F700 Bedrails o R63 has had bedrail secured to prevent entrapment or accident o All other bedrails will be reviewed for security and safety in accordance with policy o Education provided to maintenance director on monthly inspection of bedrails o Audits will be conducted two times weekly for four weeks then monthly for two months to ensure bedrails are secure o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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F 700	Continued From page 119 in and out of bed and with repositioning in bed and used the side rail to aid in mobility. R63 was large in stature and also used a walker with transfers and a wheelchair with mobility. A review of the current care plan dated 10/16/18 lacked information about R63's ability to self transfer and failed to identify the use of side rails or adaptive equipment to promote independence in mobility. On 10/19/18, at 11:07 a.m. the director of nursing reviewed the right side rail was loose, and did not feel it was an entrapment risk but it could pose a risk for accidents. The side rail was observed to be loose in Zone 3 which is described as the area between the bedrail and the mattress. The span recommended between the areas is to be less than 4 3/4 inches. This is per the recommendations from the FDA (Food and Drug Association)Guidance for Industry and FDA Staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment revised 4/10. The DON notified the maintenance department of the need to repair R63's side rail. A facility Physical Environment - Bed Rails policy dated 11/2016, identified bed rails were provided to maintain or improve mobility and directed them to "be inspected on a monthly basis to ensure they are intact and a [sic] no visible damage is seen," to help ensure safety of the resident. The policy did not provide a process for staff to use to ensure loose rails were reported and addressed timely.	F 700		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40	F 740		12/5/18

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F 740	Continued From page 120 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement interventions to address the psychosocial needs for 1 of 1 resident (R27) reviewed for mood and behavior. Findings include: R27's significant change minimum data set (MDS) of 8/13/18 identified R27 had moderate depressive symptoms. The MDS indicated R27 required limited assistance with mobility related to weakness. The diagnoses listed on R27's MDS included; cancer, seizure disorder, weakness, repeated falls, and intent to commit self harm. R27's Care Area Assessment (CAA) worksheet for Psychosocial Wel-Being dated 9/29/18, completed by social services (SS)-B identified R27 expressed little interest or pleasure in doing things. The CAA indicated this concern would be addressed in R27's care plan to address symptom relief or palliative (An approach that improves the quality of life) measures. R27's baseline care plan dated 6/4/18, indicated R27 was verbally abusive at times related to	F 740	F740 Behavioral Health Services o R27 has had comprehensive care plan review and updated to as indicated to include psychosocial needs o Residents will be reviewed for psychosocial needs as it relates to mood and behavior o Education will be provided to IDT on need for comprehensive assessment and interventions to support emotional and mental well being o Audits of psychosocial needs for mood and behavior reflected in care plan will be done two times per week for four weeks and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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anxiety and had potential for alteration in anxiety. The baseline care plan directed staff to provide resident with one to one interactions and medications as needed (PRN).

A review of R27's comprehensive care plan, dated 8/22/18 lacked an identification of alteration in psychosocial well-being as an identified problem. Also the care plan of 6/22/18 and revised care plan of 8/22/18 had no mention of psychosocial issues, even though R27 was identified to commit self harm on admission. The comprehensive care plan also lacked information regarding resident being verbally abusive with the potential for alteration in anxiety as addressed in the base line care plan.

R27's nursing assistant sheet, undated, directed staff to remind resident to sign out when he was leaving. Additionally, the staff were directed to report to nurse of any suicide intent verbalized. Staff were also directed to report to nurse of any suspicion of being under the influence of drugs or alcohol.

R27's diagnostic assessment dated 9/7/18, from the in house psychologist indicated the referral was made by the medical and treatment team to improve R27's quality of life as he was coping with a new cancer diagnosis, long-term trauma experiences and substance abuse. R27 expressed a variety of emotions which included; boredom, loneliness, and uncertainty as to what he was to do. The documentation also reflected R27 experienced auditory hallucinations at times commanding him to do something harmful. The note indicated R27 experienced shortness of breath and panic symptoms intermittently and indicated R27 had endorsed flashbacks with

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intermittent nightmares about his abusive past. The recommendations made at this time included diversional activities such as coloring books, checking in regarding thoughts of self harm or harm to others, and normalizing grief and a variety of emotions. Although recommended by psychologist, the care plan lacked the inclusion of the identified behaviors and recommended interventions.

R27's Nursing Home Visit-Progress note from nurse practitioner (NP)-A on 10/2/18, identified R27 was observed with illicit drugs at the facility and concerns of potential interaction with illicit drugs and controlled medications. The note identified upon return, R27 must be monitored for respiratory status with regard to regular narcotic and any interactions with R27's medication by nursing staff. Additionally, the note identified R27 was to have supportive care and a safe environment at the nursing home.

R27's Progress Note of 10/12/18 from the in house clinic psychologist identified R27 was found to have illicit substance use and episode of leave of absence (LOA). The note indicated collaboration with nursing and administration to the importance of validation versus questioning interaction, awareness of impulsivity, and provision of support. The note additionally identified the potential safety risk to self and others, indicating R27 became irritated with safety questions and interaction improved when staff remained neutral during interactions, and providing comfort and validating his frustrations to avoid R27 becoming frustrated. The psychologist did identify pain appeared to be a trigger for chemical substance abuse and the importance of keeping the pain managed effectively with either

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F 740	Continued From page 123 medications or diversion. R27 is also strongly motivated by family and grandchildren, offering affirmation of their admiration and love for him can facilitate harm reduction. The Progress Notes of 10/12/18, at 2:02 p.m. indicated the facility implemented a resident check every two hours to assess mood state related to safety risks for resident and others. A review of the documentation indicated no expressed thoughts of intent to commit self harm or harm to others. During interview on 10/16/18, 9:34 a.m. R27 was observed in his room, with lights off, blinds pulled, and covered with a blanket while resting on his bed. The room lacked any decorations on walls, or personal belongings. There were no reading materiel's, coloring books, papers, or photos of family and grandchildren. R27 stated he ate all meals in his room. R27 stated he had historically experienced feelings where he felt the desire to hurt either himself or hurt others but was not experiencing them now. R27 stated at those times, he left the facility for a while, going to the encampment (homeless camp), or rode the bus. R27 stated he continued to have a case worker outside of the facility and spoke with other residents. R27 stated he didn't share his level of pain with staff at times, as it takes him a period of time to become accustomed to staff/people. A review of R27's Progress Notes identified R27 had gone on leave of absences (LOA's) on six occasions since 8/1/18 including the following dates; 8/1/18-8/6/18, 8/15/*18, 8/31/18-9/3/18, 9/8/18-9/9/18, 9/25/18-9/26/18, and the episode of 10/1/18-10/10/18. R27's Progress Notes of 7/10/18 also identified R27 may have some areas	F 740		

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F 740	Continued From page 124	F 740		

in which cultural consideration should be evaluated in developing care strategies. A review of narrative notes did not identify completion of a cultural evaluation.

On 10/18/18, at 10:48 a.m. the social service (SS)-A stated R27's records were reviewed and lacked additional information related to mood state and behavior. SS-A stated the MDS assessment and CAA information identify areas of concerns and these areas should be addressed on care plan.

On 10/18/18, at 2:42 p.m. R27 stated while on leave on absence, he would often ride the train. R27 stated he has used meth, not crack, and has kept some "over" from his LOA's in the past but didn't have any at that time. R27's tone then became more hostile in nature and stated "If you want to be a cop, get a lawyer. Get out of here I don't want to talk to you. You want to be a Lucy Loo (Asian investigator), then lets end this conversation."

On 10/19/18, at 8:57 a.m. registered nurse (RN)-A stated he was aware of R27's mood and behavior concerns, as well as his extended unplanned LOA and return to facility. RN-A stated he was unsure as to who would address the concerns in the absence of a social service staff member, but would address this concern with DON and the Administrator. RN-A stated R27 has not attempted to leave facility since his return on 10/10/18. RN-A was unaware of what was the factor which initiated the every two hour monitoring, but was aware it was being completed. RN-A stated he was unaware of any other interventions to be implemented.

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On 10/19/18, at 9:25 a.m. the administrator stated the record did not address R27's mood state, altered behavior, potential of harm to self or others, or potential use for illicit drug use in the care plan and she was unaware of any specific interventions or preferences with the exception of monitoring. The administrator acknowledged this was important for staff to be aware of this.

On 10/19/18, at 9:44 a.m. the director of nursing stated R27 has had an altered mood state and recent history of illicit drug use and this should be reflected in the care plan. The DON stated R27 is currently being followed by the in house psychologist for his concerns. The DON stated the police department responded in follow up following illicit drug use and are contacted when staff are unable to manage the situation.

On 10/19/18, at 9:59 a.m. the NP stated she was present at the time R27 left the facility and described R27 as "angry and out of control." NP recounted R27 did not return that evening or for a period of time, and was unsure as to his exact date of return. During the time of his absence, NP stated she was alerted R27 was picked up on the light rail after a four days of meth use. R27 was hospitalized at that time and subsequently discharged to a family members home, and at which time he declined discharge instructions. NP stated upon his return to the facility he was to be monitored for respiratory status related to the potential interactions of illicit drugs and prescribed narcotics. Additionally, R27 was to be provided with a safe, supportive environment, and had not had any further attempts of illicit drug use.

A policy was requested for development and

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F 740	Continued From page 126 implementation of services for residents with mood and behavior concerns but was not received.	F 740		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehenisve assessment was completed for resident with sucidial ideations and explosive behaviors, and failed to direct staff on how to handle these situations for 1 of 1 residents (R54) who has explosive behaviors and sucidial ideation. Furthermore, the facility had not assessed and developed a plan to protect residents and decrease the risk of reoffending for 1 of 1 resident (R40) identified as a predatory sexual offender in the facility. Findings include: BEHAVIORS R54 stated on 10/15/18 01:56 p.m., the facility staff are disrespectful, accuses him of selling drugs, staff refuse to take care of his room and remove meal trays and do not come to my room when he requests. One day he was frustrated he threw his dinner tray which hit the wall and then fell on floor. They always deliver his food last and it's always cold. Throwing the food tray "ended me in the crazy house" and was restrained there for awhile. At 5:58 p.m. R54 continued to state	F 745	F745 - R54 no longer resides at community. -The facility contacted the department of corrections and Minneapolis police department to clarify community notification requirements of R40 - R40 social services has assessed R40 related to possible past criminal history and updated plan of care if indicated. - Other resident's who are known to have suicidal ideation, explosive behaviors have been assessed/ reviewed by social services and care plans updated if indicated. - Other Residents with known possible past criminal history have been reviewed on the public registrant search with follow up if indicated. - Education provided to IDT on requirement to comprehensively assess the behaviors and historic acts that may impact others inside the community. Additionally, they need to develop a plan of care that assists direct care staff on actions to take to handle increase	12/5/18

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he was angry and frustrated.

R54's Admission Record, undated, identified an admission date of 6/12/18, with diagnoses of adult failure to thrive and unspecified mood affective disorder. R54's admission Minimum Data Set (MDS) dated 6/19/18, identified R54 cognitively intact, poor decision making and verbal behaviors present. R54's psychosocial care area assessment (CAA) dated 6/22/18 noted "verbal behavioral symptoms directed towards others" with no care plan considerations noted for an overall objective.

Review of R54's admission records did not identify evidence of psychosocial needs reviewed. Care plan identifies focus "Verbally abusive behaviors r/t ineffective coping skills, Poor impulse control; Resistive to care r/t adjustment to nursing home. Anxiety ; Difficulties excepting [sic] facility policy rules; Behavior problem r/t psychological disorder. Makes inappropriate sexual advances/comments to staff and other professionals; " with interventions initiated 07/24/18 with revisions 08/30/18 and 09/25/18

R54's progress notes identified the following:

- 06/12/18 3:24 p.m., indicated social worker notified nurse R34 was making statements of suicidal ideation, however with no plan. Nurse Practitioner (NP)-B was paged and stated "did not feel adding medications at this time was warranted. If he begins to feel suicidal actively to transfer him to Acute Psych Services." Director of nursing updated.

-06/12/18 4:25 p.m., social service note indicated

F 745

behavioral circumstances as well as protect other residents.
- Auditing to include review of history asses current risk to self or others and care plan updated as indicated to be done 2 times weekly for 4 weeks, and then monthly for two months.
-DON/designee will report trends of all Audits to QAPI committee for 3months to review and follow up as needed.
-Compliance date 12/05/2018

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R54 "was overwhelmed and tearful." He stated that he ready to die. I did a suicide assessment and [R54] has no plan to harm himself. Resident would like to be discharged to community."

-7/2/18 4:25 p.m., DON and administrator spoke with R54 regarding altercation R54 had with another resident. Noted R54's eyes were red and he smelled like Marijuahan. CDON completed intoxication tool and went through the Drug and Alcohol policy. R54 acknowledged he was high.

-7/17/18 1:05 p.m., R54 was verbally abusive and beligerant to staff. Contacted Minneapolis Police Department (MPD) and R54 calmed after speaking with MPD.

-07/17/2018 3:44 p.m., R54 was observed out in the street stopping traffic. R54 states staff were rude to him, didn't help him and he was upset with his mom. NP-B "didn't feel that he was suicidal but attention seeking."

- 7/23/2018 4:01 p.m., indicates R34 "sent suicidal text messages to his girlfriend in room [another resident in facility] stating 'I will kill myself.' Writer and another staff spoke with R54 and discussed concerns of suicidal text message with R54 stating 'I am not going to kills [sic] myself." [R54] was put on 2 hours suicidal watch until not [sic] suicidal intent verbalized."

- 8/17/2018 R54 was observed by staff hitting another residents wheelchair with his own power chair. They were seperated. State agency and police were called. R54 was educated on discharing AMA and assessed for suicidal ideation endorsing some ideation.

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F 745	Continued From page 129 - 09/6/18 indicated R54 did not wish to go to a wound care appointment, began screaming and stated "get out of my room, I don't want to go." Staff noted wound supplies and other items strewn throughout room and later found R54 laying on floor, under bed. R54 became verbally abusive with staff who then left room, and requested evaluation by 'crisis team'. R54 was admitted to hospital for psychiatric and medical review. R54 Admission Record Face Sheet notes onset date of 09/11/2018 for Major Depressive Disorder, Recurrent, Moderate upon return from hospital. R54 Quarterly Review Assessment 09/18/2018 completed after HCMC stay noted with reentry date noted 'no' acute change in in mental status from R54 baseline; Section E: Behavior noting no presence of behavioral symptoms; R54 did not participate in Section Q: Participation in Assessment and Goal Setting. Staff assessment indicated there is no active discharge planning. R54 seen 10/5/18 by Associated Clinic of Psychology (ACP). ACP notes indicated diagnosis of post traumatic stress disorder, major depressive disorder, bereavement, cognitive impairment due to trauma history, substance abuse, and reactive attachment disorder. ACP recommended staff continue monitoring for illegal substances, staff de-escalate when conflict arises and encourage R54 to "take a break". No further evidence noted of facility social service department following recommendations or conducting further assessment for R54's depression and behaviors.	F 745		

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DON interview 10/18/18, 8:50 a.m., stated when R54 came to us he had no psychiatric diagnosis. We had no idea what his behaviors were about. One night he got out of bed, crawled under it, and had his thumb in mouth. We sent him to the hospital on 9/6/2018. He was diagnosed major depressive disorder and ACP was following him. They are increasing his psych appointments with ACP. DON stated approximately two months ago R54 was more agitated, and verbal but is better now. They want to keep him safe and calm. If we are having sucisial or mental health issues, staff call the supervisor or police department. The current LSW just started and has not met with R54 about any of his mental health issues.

Interview on 10/17/2018 9:52 a.m. the medical records director (MRD) stated they were aware of R54's verbal and physical altercations. All staff help and try to desculate his behavior.

Requested facility policy for behavior and mood assessments. Facility produced Resident Assessment Inventory (RAI) manual dated 2016.

PREDATORY SEXUAL OFFENDER
R40's Admission Record undated face sheet identified depression, schizophrenia and a historical abuse of both alcohol and cocaine. R40's admission Minimum Data Set (MDS) dated 8/30/18, identified R40 was cognitively intact and was independent with all activities of daily living (ADL). R40's MDS did not identify any know behaviors.

Hennepin County Medical Center (HCMC) dated, 09/07/18 identified R40 was admitted to the hospital for dizziness and abdominal pain. R40's HCMC History and Physical (H&P) notes

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F 745	Continued From page 131 identified under the Psycho-social section a criminal history of several felony sexual conduct charges. The Medical/Surgical History section identified R40 had sexual offenses and had registered as a predatory sexual offender. R40's Care Plan (dated 8/28/18) and the nursing assistant care sheets (undated), did not identify R40's sexual offender status, nor was there any direction of what to monitor or whom to report these offense to so other residents residing in the facility were protected. A review of R40's medical records lacked evidence of any comprehensive assessment or resident interview of R40 related sexual offender status, even after receiving R40's records from the recent return from a hospital stay. Also, there was no plan identified to decease the risk for other residents, related to R40 possibly reoffending. During interview on 10/16/18, at 3:28 p.m. the facility temporary social worker (SS-A) stated she was new and recently started her temporary work assignment at the facility. SS-A was not aware of R40 being a convicted of predatory sexual offender. The facility administrator had been assisting in the admission process. During interview on 10/16/18, at 3:28 p.m. the administrator (ADM) stated she had been processing more of the admission paperwork lately, due to a staffing change in the social service department. ADM stated all resident admissions are reviewed through the Federal sex offender website (where level 3-5 offenders are posted). They checked this and R40 was not listed. ADM stated she did not search the state	F 745		

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F 745	Continued From page 132 database, thinking if R40 was not on the Federal web page, R40 would not be on the State web site. The administrator was unaware of any sexual offense to any resident who currently resided in the nursing home by R40. Review of the Minnesota Court Information System, identified R40 had four convictions of criminal sexual conduct, 2nd degree felony, (1992, 1993, and 1994) with the most recent conviction on 5/20/15, for failing to register as a predatory offender. During interview on 10/17/18, at 10:11 a.m. registered nurse (RN)-A stated he was aware R40 was a predatory sex offender and did not know if any assessment was completed related to R40's history, nor if systems were placed to protect other residents. Although R40 was a registered offender, and the facility was aware of his criminal history, there was no plan implemented to ensure residents who lived in the facility were protected from R40's offenses.	F 745		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		12/5/18

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F 755	Continued From page 133 §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 observation, interview, and document review, the facility failed to implement policies and procedures to ensure rapid detection of potential narcotic/controlled medication diversion were implemented for 3 of 3 medication carts reviewed during the survey. This had potential to affect 26 of 26 residents with current orders for narcotic medication and/or controlled substances (medications regulated and classified by the Drug Enforcement Agency) in the facility. In addition, the facility failed to ensure narcotic medications were appropriately secured to the pharmacy supplied packaging to prevent loss and/or diversion for 6 of 6 residents (R22, R55,	F 755	F755 Pharmacy o Narcotic count has taken place on all three medication carts o All medication carts and cards reviewed for safe storage of narcotics o All medication labeling reviewed for legibility and adequate instructions o Education provided to nurses on every shift counting procedures to ensure rapid detection of potential narcotic diversion. o Education provided to licensed nurses and TMAs on proper storage of narcotics, including actions to take if a medication is removed from the card and then not	

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F 755	Continued From page 134 R62, R56, R65, R39) who had narcotic medications taped back into their packaging; and failed to ensure narcotic transdermal patches were disposed of in manners consistent with established policies and procedures to prevent diversion for 1of 1 residents reviewed who used these patches. Further, the facility failed to ensure administered medications were labeled with adequate and appropriate instructions to prevent potential administration error(s) for 1 of 1 residents (R50) observed to consume narcotic medication from a bottle. Findings include: CONTROLLED/NARCOTIC MEDICATION RECONCILIATION: The facility provided Medications-Controlled policy dated 3/14, identified controlled substances were kept under double lock in the medication room and medication carts. A count of controlled drugs was maintained by nurses of the off-going and oncoming shifts, and a corresponding procedure directed the storage of controlled substance drugs be " ... verified by inventory every 8 hours, at each shift change." Further, the policy directed a separate controlled substance administration control record is kept on all scheduled II drugs which, "...contains the amount verifiable by inventory." A facility supplied Patients On Particular Drugs Report dated 10/18/19, identified 26 current residents had orders for controlled substances and/or narcotic medications. On 10/15/18, at 1:47 p.m. the North Hallway	F 755	ingested o Education provided to licensed nurses and TMAs on proper destruction of Fentanyl patches o Education provided on appropriate labeling and instructions to prevent potential medication error o Audit will be conducted two times weekly for four weeks and monthly for two months to monitor compliance with narcotic count. o Audit will be conducted two times weekly for four weeks and monthly for two months to monitor compliance with proper storage of narcotics (not taped into "bubble") o Audit will be conducted two times weekly for four weeks and then monthly for two months to ensure proper destruction of Fentynal patches o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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F 755	Continued From page 135	F 755		

medication cart was observed with trained medication aide (TMA)-B. The cart was locked with a physical key, and the second row contained a permanently affixed lock box which contained narcotics and other controlled medications. TMA-B explained the narcotic and controlled medications were counted with each shift exchange and documented accordingly. A white colored binder labeled "North Station Total Count and Signature" was provided which contained several months of a flowsheets labeled, "Total Count and Signature Page." The flow sheets provided spacing for the departing and oncoming nurses' to sign they have counted the medications. A total of six signatures each day (two for day shift, two for evening shift and two for night shift) were required to satisfy the record.

The flowsheet for September 2018, identified of the required 180 required signatures for the month of September, there were 146 signatures documented verifying the security and accuracy of the controlled medications. The remainder of the spaces left to record signatures to demonstrate the count was completed and accurate were left blank.

The flowsheet for October 2018, identified of the required 86 signatures there were 74 signatures documented verifying security and accuracy of controlled medications. The remainder of the spaces left to record signatures to demonstrate the count was completed and accurate were left blank.

TMA-B stated they felt the controlled/narcotics were always being counted, but sometimes were not being signed off as completed. TMA-B

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explained if a count was found incorrect, they would immediately notify the supervisor. The surveyor and TMA-B completed a narcotic count of the North Hallway Cart; which was found to be correct.

On 10/15/18, at 1:57 p.m. the West Hallway medication cart was observed with TMA-B. The cart was locked with a physical key, and the second row contained a permanently affixed lock box which contained narcotics and other controlled medications. Again, a white colored binder labeled "West Station Total Count and Signature" was provided which contained several months of a flowsheets labeled, "Total Count and Signature Page." The flow sheets provided spacing for the departing and oncoming nurses' to sign they have counted the medications. A total of six signatures each day (two for day shift, two for evening shift and two for night shift) were required to satisfy the record.

The flowsheet for September 2018, identified of the total 180 required signatures for the month of September, there were 137 signatures documented verifying the security and accuracy of the controlled medications. The remainder of the spaces left to record signatures to demonstrate the count was completed and accurate were left blank.

The flowsheet for October 2018, identified of the required 86 signatures for the month of October there were 73 signatures documented verifying security and accuracy of controlled medications. The remainder of the spaces left to record signatures to demonstrate the count was completed and accurate were left blank.

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Immediately following, the surveyor and TMA-B completed a narcotic count of the West Hallway cart; which was found to be correct.

On 10/15/18 at 2:07 p.m. The South Hallway cart was observed with licensed practical nurse (LPN)-D. The cart was locked with a physical key, and the second row contained a permanently affixed lock box which contained narcotics and other controlled medications. LPN-D provided a white colored binder labeled "South Station Total Count and Signature," which contained several months of a flow sheet labeled "Total Count and Signature Page." The flow sheets provided spacing for the departing and oncoming nurses' to sign they have counted the medications. A total of six signatures each day (two for day shift, two for evening shift and two for night shift) were required to satisfy the record.

The flowsheet for September 2018, identified of the total 180 required signatures for the month of September, however, there were only 150 signatures documented verifying the security and accuracy of the controlled medications. The remainder of the spaces left to record signatures to demonstrate the count was completed and accurate were left blank.

The flowsheet for October identified of the required 86 signatures for the month of October there were 76 signatures documented verifying security and accuracy of controlled medications. The remainder of the spaces left to record signatures to demonstrate the count was completed and accurate were left blank.

Immediately following, the surveyor and LPN-D completed a narcotic count of the South Hallway

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cart; which was found to be correct.

When interviewed on 10/18/18, at approximately 10:20 a.m. the director of nursing (DON) stated staff were supposed to count the controlled medications at each shift exchange, then sign to validate taking the keys and the count accuracy. This was done to avoid discrepancies and help prevent diversion of the controlled medications.

During interview on 10/18/18, at 11:10 a.m. RN-A stated counting of narcotic medications should be done every shift change and documented by both people completing the count sign the book.

MEDICATION SECURITY / STORAGE:
On 10/15/18, at 1:47 p.m.. the North Hallway medication cart was observed with trained medication aide (TMA)-B.
During reconciliation of the controlled/narcotic medications observed R22's lyrica (controlled medication use to treat nerve and muscle pain) provided in bubble card, contained one capsule that had been taped back into card. TMA-B stated nurses and TMAs should be looking at the back of the bubble cards to look for taped in medications and were the only staff that had keys to the medication carts. If a resident refused the medication, they are brought to a nurse who discards them with you. The Director of Nursing (DON) was standing nearby and overheard the conversation, and looked at card. DON asked TMA-B, "You counted with night shift and accepted it this way?" TMA-B responded "Yes I did."

On 10/15/18, at 1:57 p.m. the West Hallway medication cart was also observed with TMA-B.

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F 755	Continued From page 139 During reconciliation of the controlled/narcotic medications observed medication bubble card for R55 oxycodone (narcotic pain medication) contained three medication bubbles that had been taped closed, R62 hydromorphone (narcotic pain medication) contained one bubble that had been taped closed On 10/15/18, at 2:07 p.m. The South cart was observed with LPN-D. During reconciliation observed R56 bubble card oxycodone contained one bubble taped, R65 lorazepam (controlled medication for anxiety) contained two taped bubbles and R39 clonazepam (controlled medication used for seizures, panic disorder, and anxiety) contained two taped bubbles and R39 lorazepam contained one taped bubble. During interview immediately following the observation, LPN-D stated if you find a pill taped in don't use it, get another nurse to sign it and dispose of it. When we count controlled medications we compare the book to the medications. Counting was completed at change of shift and when medications were signed into the count book. If the count was incorrect this is report immediately to the unit supervisor. During interview on 10/18/18, at approximately 10:20 a.m. director of nursing (DON) stated medications cannot be taped back in to the cards, it's unacceptable not a good practice to avoid diversion. We need to validate that it is indeed what it is. It's a possibility the medication could have been tampered with, there are many medications that look alike, may not get what they were prescribed. When interviewed on 10/18/18, at 11:10 a.m.	F 755		

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F 755	Continued From page 140 RN-A stated medications should never be taped back in to the cards, the process is to get a nurse and destroy the medication properly to prevent diversion. A facility Medications-Controlled policy dated 3/14, identified "If resident refuses medication: do not replace in container, destroy drug in accordance with policies of facility for destruction of refused controlled medication." Fentanyl PATCH DESTRUCTION: A facility Medications- Disposal of Used Fentanyl Patches- HDGR policy dated 4/12 identified it is the policy of this facility to properly handle and dispose of used Fentanyl (narcotic duragesic) patches in accordance with manufacturer and FDA recommendations. Definitions identify "Fentanyl in on the FDA list of medications recommended for disposal by flushing" Procedure indicates "After removing the Fentanyl patch, immediately dispose of the used patch safely by folding the adhesive sides of the patch together(until it adheres to itself) and flushing it down the toilet" During interview on 10/18/18, at 10:52 a.m. LPN-B stated Fentanyl was a narcotic and needed to be disposed of properly, by placing the Fentanyl patch in the paper shred bin, so it could not be reached. During interview on 10/18/18, at 10:55 a.m. TMA-A stated I've never changed a Fentanyl patch, and would get a nurse to show TMA-A how to do it. During interview on 10/18/18, at 11:05 a.m.	F 755		

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LPN-A stated Fentanyl patches go in the sharps container.

During interview on 10/18/18, at 11:07 a.m. RN-B stated Fentanyl patch has to have two nurses to verify and dispose of, we have a disposal bin for pharmacy, the sharps container is not an acceptable way to dispose of the patches.

During interview on 10/18/18, at approximately 10:20 a.m. director of nursing (DON) stated with narcotic destruction the nurse brings to the nurse manager they cross check it, sign off in the narcotic book. DON and nurse managers can log into Omnicare (pharmacy website) to log the destruction, separate and flush medications the toilet. When Fentanyl patches are removed, cut them into pieces with gloves on, they are supposed to bring to me like any narcotic. I know they put them in the sharps container, we remove the sharps containers every shift and box it up.

During interview on 10/18/18, at 11:10 a.m. RN-A stated Fentanyl patches goes into the black box that licensed nursed have access to. Fentanyl should not be put into sharps container or the paper shredder bin, they can be accessed by someone, need to prevent diversion.

MEDICATION LABELING:
A facility Medications-Labeling policy dated 3/14 identified Medications were labeled in accordance with state and federal laws "Drug container labels are completed by a pharmacy, including label changes. Label includes the resident's name, drug name, dose, frequency, route instructions for use, and expiration date."

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F 755	Continued From page 142 On 10/15/18, at 1:57 p.m. the West Hallway medication cart was observed with TMA-B. During reconciliation of the controlled/narcotic medications: observed one bottle of tablets for R50 with handwritten piece of paper taped to bottle identified medication as hydrocodone 325/10 mg (narcotic pain medication) with number 149 written on the label indicating page 149 in bound narcotic book. No dose, frequency, route instruction for use or expiration date was identified on handwritten label. Licensed practical nurse (LPN)-A was nearby at nurses station during the observation stated "we are not using it, we have to keep it until someone figures out what we are going to do with it" R50 "Individual Narcotic Record" located in bound book indicated resident had received doses on 10/5/18, 10/8/18 and 10/10/18. During interview on 10/18/18, at 11:10 a.m. RN-A stated medications without pharmacy labels should not be used and should be destroyed.	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	F 757		12/5/18

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F 757	Continued From page 143 §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 document review, the facility failed to ensure orthostatic blood pressure monitoring was completed for 1 of 5 residents (R44) reviewed for unnecessary medication use and who consumed antipsychotic medication on a routine basis. Findings include: R44's quarterly Minimum Data Set (MDS) dated 9/4/18, identified R44 had severe cognitive impairment, was independent with bed mobility, transfers and ambulation, and, consumed antipsychotic medication on a daily basis. R44's Hennepin County Medical Center Nursing Home Visit - Progress Note dated 10/16/18, identified R44 had physician orders for haloperidol (an antipsychotic) 5 milligrams (mg) by mouth daily with a listed start date of 8/16/18. R44's Consultation Report dated 6/26/18, identified R44 admitted to the facility with orders for antipsychotic medication and listed several recommendations for the staff to implement including, "Please ensure ... we monitor orthostatic blood pressure."	F 757	F757 Drug Regime is Free from Unnecessary drugs o R44 has had his orthostatic blood pressure completed o All on antipsychotic medication reviewed and orthostatic blood pressure obtained if indicated o Licensed nurses educated on need for orthostatic blood pressure monitoring for those residents who take antipsychotic medications o Audit will be conducted 3 times weekly for 4 weeks and monthly for 2 months to monitor compliance with orthostatic blood pressure with antipsychotic use o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 144	F 757		

During observation on 10/18/18, at 11:35 a.m. R44 was seated on his bedside in his room with his pants down around his thighs. R44 stood up at the bedside without any physical assistance or mobility devices, and pulled up his pants. R44 stated he did not need help with standing up or walking, nor had he ever had any falls and denied lightheadedness when standing or walking.

A Centers for Disease Control (CDC) Measuring Orthostatic Blood Pressure feature dated 2017, directed the following process to check a patient' orthostatic blood pressures: 1) Have the patient lie down for 5 minutes; 2) Measure blood pressure and pulse rate; 3) Have the patient stand; and, 4) Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes.

R44's Blood Pressure Summary dated 6/26/18 to 10/18/18, identified the following blood pressures (BP) had been collected: On 7/11/18, a lying BP was recorded of 137/89. On 7/16/18, a sitting BP was recorded of 112/72, and a standing BP was recorded of 122/82. R44's medical record was reviewed and lacked any evidence a set of concurrent (i.e. collected at one period) orthostatic BP(s) had been collected since the pharmacist recommended them on 6/26/18, nor had any ongoing monitoring been set up to ensure R44's orthostatic BP was collected and assessed on a routine, ongoing basis.

When interviewed on 10/18/18, at 3:56 p.m. registered nurse (RN)-A explained the process to collect orthostatic blood pressures. The resident should be laying down and have their blood pressure checked; then sit up, wait five minutes

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	245544	A. BUILDING ______ B. WING ______	C 10/19/2018

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F 757	Continued From page 145 and have it checked again; then stand up, wait five minutes and have it checked again. RN-A stated R44's medical record lacked any evidence this had been completed, nor had any routine monitoring of R44's orthostatic blood pressures been set up adding a lack of working vital sign equipment may have contributed to the issue. Further, RN-A stated it was important to ensure orthostatic blood pressures were monitored in someone taking antipsychotic medication to make sure the medication was not "adversely affecting" them. A facility policy on medication management and orthostatic blood pressure monitoring was not provided.	F 757		
F 759 SS=D	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 documentation review, the facility failed to ensure medications were administered in accordance with accepted standards of practice to prevent errors for 2 of 4 residents (R2 and R38) observed to receive medications during the survey. This resulted in a facility medication error rate of 24% (percent). Findings include: R2's physician orders signed 10/3/18, identified	F 759	F759 Free of medication Error Rts 5 Percent or More o R2 has had medications administered per G-tube according to provider orders o R38 Has received insulin in accordance with insulin pen guidelines o All residents receiving G-tube Medication or insulin through a pen were reviewed for accuracy o Licensed nurses educated on G-tube medication administration o Licensed nurses educated on proper	12/5/18

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F 759 Continued From page 146

the following medications to be given via g-tube (tube inserted through the abdomen that delivers nutrition/medications directly to the stomach.

- potassium chloride (supplement) solution 22.5 milliliters (ml) daily dilute before giving

- amlodipine (treats high blood pressure) 5 milligrams (mg) daily

- aspirin (nonsteroidal anti-inflammatory drug) 81 mg daily

- clonidine (treat high blood pressure) 0.1 mg three times daily

- famotidine (reduce stomach acid) 20 mg twice daily (BID)

- furosemide (diuretic) 20 mg BID

- lactinex (probiotic)1000000 cell 1 tab daily

During observation on 10/17/18, at 8:32 a.m. licensed practical nurse (LPN)-A prepared the above medications to administer through R2's g-tube. LPN-A crushed and dissolved each medication individually. LPN-A did not dilute liquid potassium chloride with water. LPN-A flushed g-tube with 15 ml of water, administered each medication one after another with no water flush between each medication. A final flush of 60 ml's of water was given after the last medication.

When interviewed after medication administration LPN-A stated she did not flush between each medication. She used 240 ml of water with 120 ml of it used to mix protein powder. She stated she thought R2 could not have any more water;

F 759

use of insulin pen
o Audit will be conducted 2 times weekly for 4 weeks and monthly for 2 months to monitor compliance with medication administration through G-tube and insulin pen.
o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed.
o Compliance date 12/5/2018

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F 759	Continued From page 147 however, did not clarify that with the dietician or physician. Upon reviewed of R2's potassium order, she stated she should have diluted the potassium prior to administrating. R2's physician orders lacked an orders for fluid restrictions. When interviewed on 10/18/18, at 10:45 a.m. the registered dietician (RD)-A stated R2 had no fluid restriction. R2 had an order to flush with 15 cc before and after each feeding. The 240 ml flush four times daily was her estimated daily need. It would be appropriate to dissolve each medication and flush in between each medication, this would not cause fluid over load and would provide R2 with additional fluid, which was not contraindicated. When interviewed on 10/18/18, at 11:44 a.m. RN-A stated the standard of practice was to flush after each medication given via g-tube. If the medication instructions directed the staff to dilute prior to giving the medication. He would expect the staff to do so. A policy on medication administration by g-tube was requested and not received. R38's physician orders signed 10/2/18, identified Novolog (fast-acting insulin) flexpen 100 units/ml inject subcutaneous by sliding scale before meals. R38s blood sugar reading was 192 milligrams/deciliter (mg/dl), normal blood sugar reading before meal 80-130 mg/dl. R38's sliding scale directed, for a blood sugar of 151-200	F 759		

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F 759	Continued From page 148 mg/dl, R38 was to receive 1 unit of Novolog insulin. On 10/17/18, at 7:34 a.m. LPN -A was observed obtaining R38 Novolog insulin pen from treatment cart and a needle. She applied the needle following cleaning the end of the insulin pen with an alcohol swab. LPN-A turned dial all the way back then turned dial back to one unit. LPN-A did not prime the insulin pen (to allow correct dosage of insulin in the needle) prior to dialing R38's insulin dosage. LPN entered R38's room and prepared to administer the insulin. Prior to administering the insulin the surveyor stopped LPN-A from administration. When interviewed LPN-A stated she did prime the insulin. She then demonstrated turning the insulin pen dial all the way forward and then back to 1 unit. She was not aware the insulin should be primed by dialing the insulin pen to 2 units and discarding the insulin, prior to dialing the insulin pen to the dose to be administered. When interviewed on 10/17/18, at 7:54 a.m. LPN-D stated and insulin pen was primed by dialing 2 units and discard it before dialing the insulin pen to the dose to be administered, which was called priming the pen. During interview on 10/18/18, at 11:44 a.m. registered nurse (RN)-A the standard of practice when using insulin pen was to prime with 2 units of insulin, discard, then dial in number of units needed to ensure accurate dosing. Insulin Administration policy dated 4/08, did not identify insulin administration with an insulin pen.	F 759		

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F 759	Continued From page 149 A manufacturer Guide to Using Novolog Flexpen dated 5/16, indicated prime the pen, turn dial to select 2 units, press and hold the dose button. Make sure a drop appears, turn dose selector to the number of units needed to inject. A policy on medications errors was requested and not received.	F 759		
F 836 SS=F	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud	F 836		12/5/18

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F 836	Continued From page 150 and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify all residents/representative of 1 of 1 resident (R40) felony history as a predatory offender as identified in Minnesota Statute 243.166, Registration of Predatory Offenders, Subd. 1b., and develop a care plan assessing R40's risk of abusing other residents as identified in State Statue 626.557. This had the potential to effect all 62 residents residing in the facility. Findings include: Minnesota Statute 243.166 indicated self-disclosure by a registered offender must occur to the health care facility. If law enforcement was aware a registered offender is admitted to a health care facility, law enforcement must give the administrator a fact sheet containing the following information: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of conviction; (3) the risk level classification assigned to the offender under section 244.052, if any; and (4) the profile of likely victims. Minnesota Statute section 626.557 requires facilities to develop vulnerable adult care plans assessing the person's risk of abusing other vulnerable adults. R40's Admission Record, undated, included	F 836	F836 License/Comply w/Fed/State/Loc Law/Prof Std o The facility contacted the Department of Corrections and Minneapolis Police Department to clarify community notification requirements of R40. The Level 1 Fact Sheet was received and distributed to residents or responsible party as deemed appropriate according to state law. o Social Services has assessed R40 related to possible past criminal history and updated the plan of care. o Other residents with known possible past criminal history have been reviewed on the Public Registrant Search with follow up if indicated. any information received from Minneapolis police department with level 1,2, 0r 3 will distributed to residents or family members according to state law. o IDT and Licensed nurses educated on R40□s behaviors. o Audit will be conducted 2 times weekly for 4 weeks and monthly for 2 months to monitor compliance with notification requirements. o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date 12/5/2018	

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F 836	Continued From page 151	F 836		

admission date 8/23/18, with diagnoses of alcohol and cocaine abuse, unspecified psychosis (mental illness typically characterized by radical changes in personality, impaired functioning, and a distorted or nonexistent sense of objective reality) not due to substance or known psychological condition, and single episode major depressive disorder. R40's admission Minimum Data Set (MDS) dated 8/30/18, identified R40 was cognitively intact and was independent with all activities of daily living (ADL) and had no known behaviors or mood indicators identified.

Hennepin County Medical Center (HCMC) dated, 09/07/18, identified R40 was admitted to the hospital for dizziness and abdominal pain. R40's HCMC History and Physical (H&P) notes identified under the Psycho-social section a criminal history of several felony sexual conduct charges. The Medical/Surgical History section identified R40 had sexual offenses and had registered as a sexual offender.

Review of the Minnesota Judicial Branch Court Information System website identified R40 was convicted of four instances of Criminal Sexual Conduct, 2nd Degree Felony, (1992, 1993, and 1994) with conviction on 05/20/15 for Registration of Predatory Offender.

Review of R40's medical record did not identify any additional information that R40 was a registered sex offender, nor was there any information the facility has contacted law enforcement for a fact sheet identifying: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of conviction; (3) the risk level classification assigned to the offender under section 244.052, if

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F 836	Continued From page 152 any; and (4) the profile of likely victims. There was no assessment of R40's behavior or plan to assist staff so other residents who lived in the facility were kept safe. During interview on 10/16/18, 3:28 p.m. the facility temporary social worker (SS)-A stated she was new and started her temporary work assignment after the survey team arrived at the facility on 10/15/18. SS-A was not aware that R40 was a convicted sex offender. Interview 10/16/18, 3:29 p.m. the administrator stated she had been processing more of the admission paperwork due to a staffing change in the social service department. Administrator stated she conducted a search through a federal sex offender web site and did not find R40 listed but did not search any state of Minnesota databases identifying predatory sexual offenders. She was unaware R40 was a predatory offender. During interview 10/17/18, 10:00 a.m. trained medication assistant (TMA)-C stated she was unaware of any residents currently residing in the facility that were known sexual offenders. TMA-C stated if there was a resident identified by the facility, the staff would watch the resident, where they were within the facility and who they were visiting. If they saw a vulnerable resident being harmed, the staff should separate and contact the administrator and director of nursing. Interview 10/17/18, 10:07 a.m. nursing assistant (NA)-F stated she was not aware of any residents within the facility that were known sexual offenders. NA-F further stated that if there were, she suspected staff would be required to monitor the whereabouts of that person, and intervene if a	F 836		

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F 836	Continued From page 153 situation with another resident arises, separate and report to the administrator and director of nursing. During interview 10/17/18, 10:11 a.m. registered nurse (RN)-A stated he was aware R40 was a predatory sex offender and did not know if any assessments were completed related to R40's history, nor if systems were placed to protect other residents. Although R40 was a registered offender, and the facilty was aware of his criminal history. The facility made no attempts to contact law enforcement and notify residents and their families that a predatory offender lived in the facility. Also, there was no plan implemented to ensure residents who lived in the facility were protected from R40's offenses. Minnesota Statute 244052 Predatory Offenders; Notice identified the following risk levels: Risk level I: assessment score indicates a low risk of re-offense. Risk level II: assessment score indicates a moderate risk of re-offense. Risk level III: assessment indicates a high risk of re-offense.	F 836		
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.	F 880		12/5/18

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F 880	Continued From page 154 §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 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	F 880		

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F 880	Continued From page 155 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 implement a comprehensive infection control program to include timely surveillance data and a comprehensive analysis which identified interventions when patterns and trends were identified. Further, the facility failed to ensure all the infection control policies were created and reviewed on an annual basis. This had the potential to effect all 62 residents currently in the facility. In addition, the facility failed to ensure appropriate hand hygiene practices were completed when in contact with bodily fluids for 1 of 1 residents (R2) observed during perineal cares Findings include: The facility form, Victory Infection Control Log were reviewed from August 2018, through	F 880	F880 – Infection Prevention and Control o R2 has had cares with appropriate hand hygiene o An Infection control program has been developed and initiated to monitor and analysis for any trends or patterns of infections to reduce the potential transmission to other residents. o Surveillance for infection is ongoing for all residents o Infection control resource information available for nurses o Nursing staff re-education on proper hand hygiene o Re-education has been provided to nursing staff on infection control surveillance, monitoring and trending of infections. o Audits of hand hygiene will occur 5	

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F 880	Continued From page 156	F 880		

October 2018 were reviewed. The information collected was organized with several columns and rows to record the identified data and each resident's illness. The data collected, according to the columns, included: Resident Name; Date of Onset; Room #, Signs and Symptoms, X-Ray Results, UA Results, Medications, Precautions, Admitted, In House Acquired, Date Resolved. The log did not identify site/type of infection.

August 2018, Victory Infection Control Log only identified actual infections treated with medications. The line listing did not include the site/type of infection. The line listing identified residents in non sequential order, not when the infection started. The corresponding analysis dated 8/31/18, identified new nosocomial (originating in a hospital.) infections at a rate of 1.7 percent with a prevalence of infections of a rate of 55 percent. The analysis identified three wound/skin infections, two urine infections and four other infections. There was no written analysis of whether trends or patterns were identified and what was implemented to reduce the spread of infection.

September 2018, Victory Infection Control Log 2018, only identified actual infections treated with medications. The line listing did not include the site/type of infection. The line listing identified residents in non sequential order, not when the infection started. The corresponding analysis dated September 2018, identified new nosocomial (originating in a hospital.) infections at a rate of 61% percent with a prevalence of infections of a rate of "0.122 %". The analysis identified one urine infection and 1 enteric (relating to or occurring in the intestines) infections. There was no written analysis of

Provider's Plan of Correction (F 880):

times per week for four weeks and then 5 times monthly for 2 months.
- o Audits will occur two times weekly for 4 weeks then monthly for 2 months to ensure infection control surveillance is accurate and ongoing.
- o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed.
- o Compliance date. 12/5/2018

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VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 880	Continued From page 157	F 880		

whether trends or patterns were identified and what was implemented to reduce the spread of infection.

October 2018, Victory Infection Control Log was completed to 10/15/18, only identified actual infections treated with medications. The line listing did not include the site/type of infection. The line listing identified residents in non sequential order, not when the infection started.

On 10/18/18, at 2:31 p.m. registered nurse (RN)-B, the facility infection prevention coordinator (IP) was interviewed along with the director of nursing (DON). The DON stated at "QAAPI [Quality Assurance, Assessment and Performance Improvement] meetings the doctor goes into detail and he is our oversite. When I give him the numbers and information he asks me why we have these numbers and the doctor recommends changes. The doctor puts them in his notes's." DON states there is no reference outside of doctors notes and QAAPI minutes for staff follow.

During interview on 10/18/18, 2:31 p.m. with the director of nursing (DON) and registered nurse (RN)-B infection control nurse (ICN), indicated RN-B did not actively participate in infection control process. RN-B shared the DON was managing the program. DON shares training starts "from the beginning, it's part of the orientation checklist and then once on the floor we re-enforce." The DON was unaware of what documentation would be needed to accurately and thoroughly perform all aspects of the infection control program.

There was no policy provided for the facility's

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infection control program when requested during and following the survey.

GLOVE USE:

R2's annual Minimum Data Set (MDS) dated 9/25/18, identified R2 was in a persistent vegetative state (no discernible consciousness) and was totally dependent on staff for their activities of daily living (ADL's).

During observation on 10/16/18, at 3:02 p.m. nursing assistant (NA)-C removed R2's soiled brief containing a smear of bowel movement and a small amount of urine. NA-C provided peri-care, removed her dirty gloves, hand hygiene not performed then applied clean gloves. NA-C performed hand hygiene prior to leaving room.

Immediately following morning cares, during interview NA-C stated did not perform hand hygiene after removing gloves. It was okay to remove dirty gloves and put on clean gloves without performing hand hygiene, however, hand hygiene needed to be completed before starting any care and then after providing care.

During observation on 10/17/18, at 9:06 a.m.

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NA-F with gloved hands removed R2's brief containing a small amount of urine, provided peri-care. NA-F removed her soiled gloves, did not perform hand hygiene and then applied clean gloves. NA-B cleansed R2s back and buttocks, removed soiled gloves, no hand hygiene performed prior to applying clean gloves. NA-F applied a clean brief. NA- B and NA-F dressed R2 in street clothes. NA-B and NA-F removed gloves, and did not complete hand hygiene. NA-B operated and maneuvered hoyer lift. NA-F using handle moved broad chair guided R2 into proper position. NA-B removed gloves, performed no hand hygiene, applied new pair of gloves, brushed R2s hair.

During interview on 10/17/18, at 9:53 a.m. NA-F stated they had not performed hand hygiene after removal of their gloves. They were instructed to use hand sanitizer or wash with soap and water every time gloves removed. NA-B acknowledged the same.

When interviewed on 10/19/18, at 9:19 a.m. director of nursing (DON) stated the staff were instructed to perform hand hygiene after removing gloves, especially when in contact with bodily fluids.

A facility Hand Washing policy dated 4/08, identifed "The facility requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Hand washing is also conducted per recommendations from the CDC (Center's for Disease Control) guidelines."

CDC guidelines dated 10/02, indentified glove use was expected when coming in contact with

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F 880	Continued From page 160 any body fluids and hand hygiene was to be completed after glove removal.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance. This deficient practice had the potential to affect all 62 residents who resided in the facility. Findings include: The facility form, Victory Infection Control Log were reviewed from August 2018, through October 2018. The information collected was organized with several columns and rows to record the identified data and each resident's illness. The data collected, according to the columns, included: Resident Name; Date of Onset; Room #, Signs and Symptoms, X-Ray Results, UA Results, Medications, Precautions, Admitted, In House Acquired, Date Resolved.	F 881	F881 Antibiotic Stewardship Program o An antibiotic Stewardship policy has been developed with protocols to help reduce unnecessary antibiotic use and reduce potential drug resistance o All current antibiotics reviewed for appropriate use and follow up if indicated o Education provided to nursing staff on antibiotic stewardship policy and procedures o Education provided to clinicians, residents and families on antibiotic resistance and opportunities for improvement o Audit of antibiotic stewardship reviews will be conducted two times weekly for four weeks and monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as needed. o Compliance date. 12/5/2018	12/5/18

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F 881	Continued From page 161	F 881		

August 2018, Victory Infection Control Log only identified actual infections treated with medications with 10 antibiotics prescribed. The line listing did not consistently identify appropriate use of antibiotics. Eight infections on the line listing did not identify lab results/ culture results where appropriate. There was no evidence any of the antibiotics prescribed were reviewed for appropriate use.

September 2018, Victory Infection Control Log 2018, only identified actual infections treated with medications. Four antibiotics were prescribed. The line listing did not consistently identify appropriate use of antibiotics. Four did not identify lab results/culture results where appropriate. There was no evidence any of the antibiotics prescribed were reviewed for appropriate use.

October 2018, Victory Infection Control Log was completed to 10/15/18, only identified actual infections treated with medications. Five antibiotics were prescribed. The line listing did not consistently identify appropriate use of antibiotics. Five infections on the line listing did not identify lab results/ culture results where appropriate. There was no evidence any of the antibiotics prescribed were reviewed for appropriate use.

On 10/18/18, at 2:31 p.m. registered nurse (RN)-B, the facility infection prevention coordinator (IP) was interviewed along with the director of nursing (DON). The DON stated at "QAAPI [Quality Assurance, Assessment and Performance Improvement] meetings the doctor goes into detail and he is our oversite. When I give him the numbers and information he asks me why we have these numbers and the doctor

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F 881	Continued From page 162 recommends changes. The doctor puts them in his notes's." DON states there is no reference outside of doctors notes and QAAPI minutes for staff follow. The facility policy Antibiotic Stewardship Program (ASP) dated 10/14/17, identified the facility was to develop it's individual ASP mission statement/leadership support statement, form an ASP team, monitor antibiotic usage patterns on a regular basis, review antibiotic use summaries and reports, utilize established criteria to educate and guide antibiotic preserving, flagging multi-drug resistant organisms (MDROs), MDRO tracking, note pharmacy consultant, report findings to QAAPI committee and education on appropriate use of antibiotics. Diagnostic testing results, including microbiology, did not appear for clinical decision making and infection surveillance. No process noted to identify when the antibiotic use were reviewed or how the facility would communicate inappropriate antibiotic use.	F 881		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §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 maintain a clean, sanitary and pleasant- smelling environment for 2 of 2 residents (R63, R29) who expressed concerns about odors and dirty carpeting in the building. Additionally, the failure to maintain a	F 921	F921 - Room number 144 has had deep clean including floor - Room number 150 has had deep clean	12/5/18

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F 921	Continued From page 163 clean and odor-free environment had the potential to affect 18 current residents who resided in north hallway (rooms 100-114); and 21 current residents who lived in the south hallway area (Rooms 142 -156); as well as any visitors and staff of the nursing home. Findings include: R63's admission Minimum Data Set (MDS) dated 10/3/18 indicated R63 had intact cognition. When interviewed on 10/15/18 at 2:44 p.m. R63 stated the smell in the building was "concerning." R63 stated the hallway smells of feces, that she has expressed this to staff, "but there is no improvement." R63 shrugged her shoulders and stated "What can they do?" During observation on 10/15/18, at 6:27 p.m., in the north hallway area of the nursing home, there was extreme and prevalent smell of urine. In a resident room, 112, there was pink-colored stain on the carpet, approximately 12" (inches) by 12" in the middle of the room. During observation on 10/16/18 at 8:22 a.m., it appeared the main hallway carpeting from the entry way toward the nursing station had just been cleaned, as there were water streaks running the length of the hall, where the carpet had not yet dried. The dampness of the carpet, along with the warmth in the hallway intensified the lingering smell of urine which was prevalent in the main hall carpeting. R29's admission MDS dated 2/16/18 indicated intact cognition. During interview on 10/15/18 at 3:01 p.m. R29 stated there is the smell of urine in	F 921	including floor. - Room number 112 has had deep clean including floor. - Room number 188 has had deep clean including floor. - All other rooms reviewed for stains on floor and treated if indicated. -North and South hallway areas have been shampooed and cleaned. -Housekeeping staff educated and will be responsible for monitoring. -Audits will be completed 2 times per week for 4 weeks and monthly for 2 months to assure compliance for clean flooring. -Audits will be reviewed in QAPI for 3 months. -Compliance date 12/05/2018	

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F 921	Continued From page 164	F 921		

Continued From page 164

the hallway. R29 stated he was frustrated with the staff, that they won't clean the dirty floor. "I think the cleaning lady misses me," R29 stated.

A Common Entry Point Intake form, dated 9/1/18, identified a complaint with the facility. The report indicated "Every time reporter is visiting at facility, a strong odor of feces and urine permeate the air." The complaint report also indicated the carpets were not clean. The reporter visited at the facility on multiple occasions and the facility "has not fixed the urine and feces smell." The report did not indicate a specific room or area, only that the facility failed to provide a safe, clean, comfortable and homelike environment.

During interview on 10/19/18 at 8:43 a.m. nursing assistant (NA)-G pointed out numerous stains on the carpets, saying you don't have to look far to find the stains or smell the carpets. NA-G stated the whole carpet in the dining area need to be changed, "it just smells so bad." NA-G stated that while the carpets were frequently washed, "I doubt now it does any good." They can clean and clean and the spots "won't come out." NA-G stated "Simply put, its just kinda old, and it smells." NA-G stated she has worked on many wings in the building, that today she was working on the south unit, but that it was dirty all over the place.

When interviewed on 10/19/18 at 9:02 a.m. nursing assistant (NA)-H stated she works all over in the building, and sighed, then stated she thought the carpets likely had been laid down "when the building went up." NA-H stated the carpets in resident bedrooms, hallways, by the nursing desk, were just stained, and "you know what smell is out there."

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When interviewed on 10/19/18 at 9:06 a.m. activities assistant (AA)-A stated "Let's face it, the carpet in the building "smells like urine." AA-A stated the problem with the carpets is that "they are old, period." AA-A stated she thought the carpeting has been down for almost fifteen years, and thinks they were recently changed about that long ago, when ownership had changed. AA-A stated it was an aging thing, "we all get old" and as things age "they need to be replaced."

When interviewed on 10/19/18 at 8:27 a.m., housekeeper (HSK)-A stated there odors from the carpeting, then paused and said "I think they are trying to stay on top of that." HSK-A stated the hallways were clean nearly daily and the main sections "were cleaned everyday." HSK-A stated there were areas that smelled more than others, the most prevalent smell was of urine, and it can be "more so" when the carpets were wet.

When interviewed on 10/19/18 at 8:52 a.m., HSK-B acknowledged the floors, carpeting was dirty, and that "it smelled," especially in certain areas and more so in certain rooms. HSK-B stated while some of the smell and odors could be attributed to body odor, there are rooms and hallways that have a permanent "urine and BM (bowel movement) odor. HSK-B stated the carpet in general was full of soiled and staining spots, by the nursing station, in resident rooms, hallways and just in general.

A brief tour of the facility was made with the environmental services director (ESD) and joined by the facility administrator beginning at 9:55 a.m. on 10/19/18. During the tour the ESD and administrator acknowledged odors in the open

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areas, and numerous stains in the carpets in the north, south and west hallways, the area surrounding the nursing station, as well as floor stains in resident room #144, #150, #112 and #186.

When interviewed on 10/19/18 at 10:05 a.m., the environmental services director (ESD) stated maintenance had been working to keep the carpets clean, and that it was obviously "on going" and "there was definitely a lot of work to be done." The ESD stated there were odors present in the carpets, including that of urine. The ESD stated that shortly after he arrived during a safety meeting he suggested and advocated "the carpets be replaced" and thinks that will be part of a future plan, but there was no defined timetable now. The ESD stated he was "not aware and questioned" if there was a formal cleaning schedule for the carpet.

When interviewed on 10/19/18 at 10:20 a.m., the administrator stated the dirty, soiled carpets had been an issue from the last survey. The administrator acknowledged there were stains and juice spills, "some you just can't get out," and urine odors, and the carpets were "still a concern." The administrator stated the main traffic areas were getting cleaned often and "we are washing them constantly," but could not say if there was a schedule to clean individual resident rooms, but "we try to clean them right away." The Administrator stated there were plans of new owner and maybe new carpet, "but that has not happened," however it was still the plan. The administrator stated "we know we try to make work with what we have," and try make the building "as homelike as possible."

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F 921	Continued From page 167 A facility policy, Environment - Quality of Life, dated April 1, 2008, indicated the facility cares for its residents in a manner and in an environment that promote maintenance or enhancement of each resident's quality of life. Further, the policy indicated, the facility provides a safe, clean, comfortable, and homelike environment, allowing the resident to use his/her personal belongings to the extent possible.	F 921		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff kept facility doors closed and resident rooms free of food debris to minimize the continued problem of rodents entering the facility building. This had potential to affect all 60 residents (R62, R40, R115, R56) in the facility. Findings include: During observation on 10/16/18 at 2:15 p.m. R62 was seated and propelling self in her wheel chair through the main dining area toward an door, leading to an outside patio. R62 told nursing assistant (NA)-I she wished to smoke, and NA-I opened the door, and R62 entered the outdoor patio are to smoke, and NA-I closed the door about three-quarters shut. The patio door remained partially open the entire time R62 was outside, about 12 minutes. R62 returned to the door at 2:27 p.m., was assisted over the	F 925	F925 Maintains Effective Pest Control Program o R62 no longer resides at the community. o R40 was interviewed about observing rodents. o R115 no longer resides at the community. o R56 was interviewed about observing rodents. o All resident rooms and common areas reviewed for common evidence of rodents. o Patio door will be observed and repairs made if indicated. o All resident's rooms and common areas cleaned daily with focus on ensuring no food particles on floor in rooms. o Pest control contractor will make monthly and PRN visit to ensure effective	12/5/18

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F 925	Continued From page 168 threshold and made her way in the dining room. NA-I partially closed the patio door, but it was not shut tight, as another resident remained outside and was smoking. During interview on 10/15/18 at 2:58 p.m. R40 stated they have mice here in the building, "I saw them on the floor." During interview on 10/17/18 at 8:29 a.m., R115 stated there was a mouse trap in her room between the two beds. R115 stated mice "are cute in children's stories, but not when you're in a care center." R115 stated she saw a mouse in her room earlier in the morning "scurry from under the closet door and then out of the room into the hallway," adding that "was not the best part of my morning." During interview on 10/17/18 at 8:29 a.m., R56 reported he saw a mice "about three in the morning" and a second time around five-thirty a.m. "when staff came in the room." R56 stated the mouse ran along the closet side of the room, then must have turned around. R56 stated "I saw it in front of the dresser" and then it ran out. When interviewed on 10/17/18 at 8:44 a.m. staffing coordinator (SC) stated she had not seen a mouse, but "I've heard about mice." The SC stated she thought pest control came here monthly, but was not sure what else was being done about the problem. When interviewed on 10/17/18 at 12:50 p.m. housekeeper (HSK)-A stated she saw "one live mouse and one dead one" about a week before last. HSK-A stated she was not sure of the plan but has seen maintenance staff place traps and	F 925	pest control environment o Audits by interview of 5 residents per week for four weeks and then monthly for 2 months to determine if rodents are being observed and reported o Maintenance or designee will audit patio door 2 times weekly for 4 weeks and monthly for 2 months o Pest control reports will be audited for every visit o Audits will be reviewed in QAPI for 3 months o Compliance date 12/5/2018	

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pest control in the building. HSK-A stated she felt there needed to more work to keep resident rooms less cluttered, and try and "keep things off the floor and food out of the rooms."

When interviewed on 10/19/18 at 8:47 a.m. maintenance worker (MW)-A stated he has set up mouse traps as needed, and added the last time he had a mouse was "last week" in a a room "on the south hallway." MW-A stated the mice issue was addressed by the guys from "extreme" pest control.

When interviewed on 10/19/18 at 9:02 a.m. nursing assistant (NA)-H stated she has never seen a mouse in the kitchen, and "If I did, good Lord, I've have a heart attack." NA-H stated she was aware of the trap set up in the kitchen by the dishwasher area.

During interview on 10/19/18 at 9:18 a.m. the pest control provider (PCP) stated mice have been a chronic and on-going issue at the facility. The PCP said he is frequently at the nursing home, usually monthly, and has serviced rodent traps and provided the facility with different kinds of traps for mice. The PCP stated he was just at the facility, when the inspectors were there, and said he saw the door near the dining room and patio area "wide open without supervision" and has also observed "the back door where staff are" also to be open and added "you can see why" mice continued to be the facility. The PCP stated his take on what it would take to eliminate the mice, would be "some general cleaning," making sure there were no places for mice to get food and hide out, and "maybe some staff education, using common sense." The PCP stated "You have to help me help you."

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	245544	A. BUILDING ______ B. WING ______	C 10/19/2018

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A review of "Maintenance Requests" log from 7/6/18 through 10/19/18 indicated one concern related to a mouse, dated 10/9/18, "room 146, Mice."

"Xtreme Pest Solutions" receipts from April to October 2018 were reviewed and indicated the following:
--4/18/18 Unit #155 was baited due to rodent reports; other rodent devices serviced and no activity found.
--4/27/18 treated/baited kitchen/dining and #155 for mice
--5/1/18 exterior bait stations re-filled for rodent control
--6/5/18 Mice reported around exterior and all bait stations were serviced
--7/12/18 All interior and exterior rodent devices were serviced and no activity was found or reported
--9/11/18 All rodent devices were serviced and no activity found
--10/12/18 facility serviced
--10/16/18 rodent devices serviced; 2 mice caught in laundry area and 1 in kitchen area

During interview on 10/19/18 at 10:20 a.m. the administrator acknowledged there had been issues with mice, but the facility had taken a number of steps to mitigate that. The administrator stated they have been educating residents about not bringing in foods into the rooms, and giving resident plastic bins in which to store foods. The administrator stated the pest control company has been on top of things doing a good job, and feels both facility and pest control react quickly to mouse issue, that its not ignored. The administrator also stated staff need to be

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F 925	Continued From page 171 making sure the rooms are cleaned of food timely, and also to monitor the entrances and exits. The administrator also expressed frustration with the general problem of the mice. A policy regarding pest control was requested, but none was received. A facility policy, Environment -Quality of Life, dated April 1, 2008, indicated the facility provides a safe, clean, comfortable, and homelike environment, allowing the resident to use his/her personal belongings to the extent possible.	F 925		

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	245544	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/22/2018**

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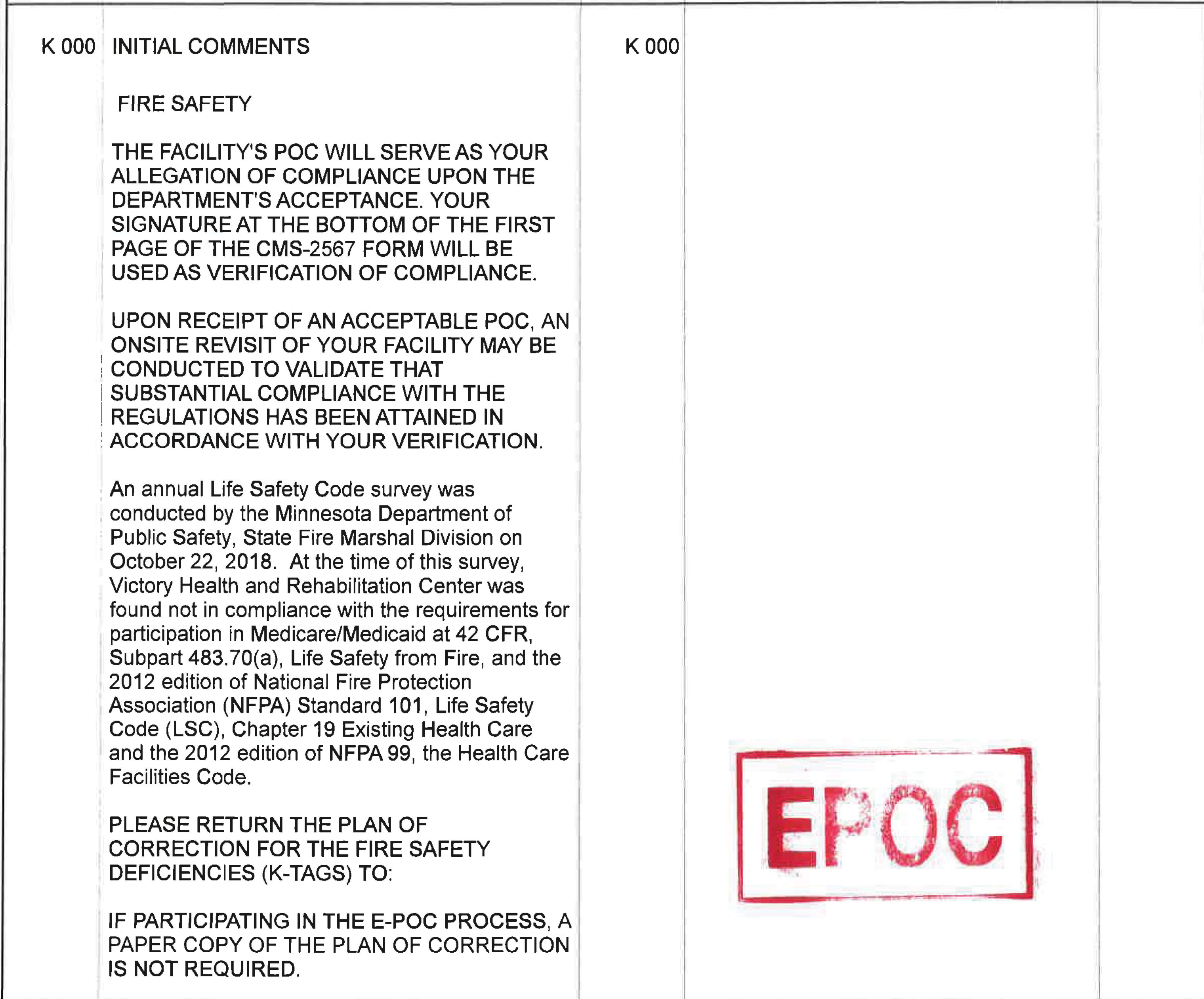
VICTORY HEALTH & REHABILITATION CENTER	**512 49TH AVENUE NORTH** **MINNEAPOLIS, MN 55430**



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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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 22, 2018. At the time of this survey, Victory Health and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/16/2018

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		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@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.

Victory Health & Rehab Center is a 2-story building with a partial basement that was built in 1990 and was determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is centrally monitored for automatic fire department notification.

The facility has a capacity of 87 beds and had a census of 60 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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

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K 345	Continued From page 2	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not maintain the fire alarm system in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code with records of maintenance and testing being readily available. 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could effect all 60 residents. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on October 22, 2018, document review revealed that the facility could not provide evidence of a current smoke detector sensitivity test. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 345	K345 Could not provide evidence of a current smoke detector sensitivity test o Sensitivity test completed by professional vendor o TELS system updated and schedule in place to complete this testing annually. Maintenance director educated on K 345 and will be responsible for monitoring going forward. o Audits will be reviewed in QAPI for 3 months o Compliance date: 12/5/2018	12/5/18
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		12/5/18

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K 712	Continued From page 3 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility did not conduct fire drills at unexpected times and varied conditions. The facility also did not verify the transmission of a fire alarm signal when fire drills were conducted. This is not in accordance with 2012 edition of NFPA 101, Life Safety Code, Section 19.7.1.4. This deficient practice could affect all 60 residents. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on October 22, 2018, it was revealed that the facility could not provided evidence of having conducted a fire drill for third shift during second quarter of 2018, and for the second shift during the third quarter of 2018. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 712	K712 Fire Drills - Fire drills completed on all 3 shifts - TELS system updated and schedule in place to meet expected and unexpected times at least quarterly on all 3 shifts -Maintenance Director educated on K712 and will be responsible for monitoring going forward. -Audits will be reviewed in QAPI for 3 months - Compliance date 12/05/2018	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		12/5/18

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K 761	Continued From page 4 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed test and inspect fire doors on and annual basis on accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect all 60 residents. Findings included: On a facility tour between the hours of 10:00 AM and 3:00 PM on October 22, 2018, it was revealed that the facility could not provide evidence of having completed an annual fire door inspection. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 761	K761 Maintenance, Inspection and Testing Doors -Door inspection and testing completed in accordance with NFPA 80 standard for fire doors and other opening protective. -TELS system updated and schedule in place to complete this testing annually. -Maintenance director educated on K761 and will be responsible for monitoring going forward. -Audits will be reviewed in QAPI for 3 months -compliance date 12/05/2018	
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters	K 781		12/5/18

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K 781	Continued From page 5 Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, The facility did not properly implement a portable space heater policy within accordance with NFPA 101, Life Safety Code, Section 19.7.8. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on October 22, 2018, it was revealed on October 15, 2018 health surveyor reported seeing a portable space heater in use in Room 151. After an interview with the resident, she admitted to the use of a space heater, but said that the heater is not in her possession anymore. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 781	K781 Portable Space heaters - Portable space heater was removed from residents room - Bi-monthly audit in place. - Maintenance Director, IDT, and nursing staff educated on K781 and will be responsible for monitoring. -Audits will be reviewed in QAPI for 3 months -Compliance Date 12/05/2018	