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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BV4T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**
2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT RUSH CITY LLC**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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) **03/01/2017**

6. DATE OF SURVEY **2/27/2018** (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 **49** (L18)
13.Total Certified Beds **49** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria Reyes, HFE NE II 03/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/16/2018 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

On January 5, 2018, a standard recertification survey was completed by MDH surveyors at this facility. The most serious deficiency identified during the survey was at a scope and severity (S/S) level of "G" for F-686 – Treatment/Services to Prevent/Heal Pressure Ulcer. This meets the No-Opportunity-To-Correct Criterion. The facility has not been cited at a S/S of "G" or above in the past two calendar years.

As a result, we imposed the Category 1 Remedy of State Monitoring, effective January 29, 2018.

In addition, we recommended the following enforcement remedy to the CMS RO for imposition:

- Civil Monetary Penalty for deficiency cited at F-686.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245348

March 16, 2018

Ms. Kathryn Trucco, Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

Dear Ms. Trucco:

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 February 23, 2018 the above facility is certified:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

Electronically delivered
March 20, 2018

Ms. Kathryn Trucco, Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: Project Number S5348027

Dear Ms. Trucco:

On January 24, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective January 29, 2018. (42 CFR 488.422)

- Civil money penalty of F686 for the deficiency cited at F686 (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on. 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 February 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on 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 a standard survey, completed on January 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2018, as of February 23, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 23, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of January 24, 2018:

- Civil money penalty be imposed. (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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BV4T

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Facility ID: 00994

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2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
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(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

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) **03/01/2017**

6. DATE OF SURVEY **01/05/2018** (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

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria Reyes, HFE NE II 02/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 02/28/2018 (L20)

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____ 2. Facility is not Eligible
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(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
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DETERMINATION APPROVAL

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

On January 5, 2018, a standard recertification survey was completed by MDH surveyors at this facility. The most serious deficiency identified during the survey was at a scope and severity (S/S) level of "G" for F-686 – Treatment/Services to Prevent/Heal Pressure Ulcer. This meets the No-Opportunity-To-Correct Criterion. The facility has not been cited at a S/S of "G" or above in the past two calendar years.

As a result, we imposed the Category 1 Remedy of State Monitoring, effective January 29, 2018.

In addition, we recommended the following enforcement remedy to the CMS RO for imposition:

- Civil Monetary Penalty for deficiency cited at F-686.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 24, 2018

Ms. Amy Floy, Administrator
The Estates at Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: Project Number S5348027

Dear Ms. Floy:

On January 5, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby significant corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 29, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F-686. (42 CFR 488.430 through 488.444)

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 5, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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
	245348	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/2/18 - 1/5/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 1/2, through 1/5/18, by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 636 SS=D	Comprehensive Assessments & Timing 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	F 636		2/23/18

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

Electronically Signed | 02/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 636	Continued From page 1	F 636		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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F 636	Continued From page 2 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 record review, the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of resident needs for 1 of 2 residents (R30) reviewed for nutrition. Findings include: R30's Admission Record printed 1/5/18, included diagnosis of cerebral infarction (stroke), hemiplegia and hemiparesis (complete paralysis of one side of the body). R30's Order Review Report active 10/31/17, thru 1/31/18, included physician's orders for nothing by mouth (NPO) and Glucema 1.5 Cal or equivalent, to run continuous at 40cc/hr via Jejunostomy (tube feeding) tube. R30's Care Area Assessment (CAA) for Nutritional Status dated 11/07/17, identified R30 had a nutritional status problem, but lacked any	F 636	All residents have the potential to be affected if a comprehensive analysis of the resident's needs are not included in the Care Area Assessments (CAA's). The CAA for R30 has now complete with a comprehensive assessment in place that addresses the resident's specific needs. Care Plan for R30 updated accordingly. All other residents with triggered CAA's will be audited and reassessed by correction date. These audits will be done for all residents, 8 residents per week, one at a time, for 4 weeks to ensure all residents CAAs are accurate and complete. Facility will also continue to complete all triggered CAAs with scheduled MDS and significant changes. MDS nurse will ensue CAAs are accurate and complete for each and every MDS before submitting it. IDT, which includes the Registered Dietician and Dietary Manager, have been	

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F 636	Continued From page 3 further assessment. R30's CAA for Feeding Tube dated 11/09/17, indicated R30 had a feeding tube utilized for nutritional support because of dysphagia (inability to swallow) following a cerebral infarction (stroke) and NPO status. The CAA lacked any further assessment. On 1/5/18, at 9:15 a.m. the director of nursing (DON) was interviewed and stated R30's nutritional needs should have been considered in the assessment.	F 636	provided education on writing CAAs analysis as triggered by the MDS. IDT will review audit results at quarterly QAPI meetings for sustainable solutions. Dietary Manager, Social Worker, Activities Director, MDS nurse, DON are responsible.	
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 ensure the MDS accurately reflected resident's status for pressure ulcers for 1 of 4 residents (R10) reviewed for pressure ulcers. Findings include: R10's Admission Record printed 1/4/18, indicated R10's diagnoses included demyelinating disease of the central nervous system (condition that results in damage to the myelin sheath or protective covering that surrounds nerve fibers in the brain, optic nerves and spinal cord, causing nerve impulses to slow or stop and neurological problems), progressive multifocal leukoencephalopathy (caused by a virus that	F 641	MDS for affected resident (R10) was modified and reflects accurate coding for pressure ulcers. R10 expired 2/4/2018. Will review all resident's with pressure ulcers or at risk for pressure ulcers to ensure accuracy of MDS. Modifications will be completed as needed to reflect accurate assessment and coding. MDS Coordinator was re-educated on the importance of doing a thorough assessment of pressure ulcers and coding of the MDS. DON or designee will conduct audits of pressure ulcer assessment and MDSs to	2/23/18

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F 641	Continued From page 4 destroys the myelin in the brain), spastic paraplegia (paralysis of the legs), muscle weakness, and dementia. R10's significant change Minimum Data Set (MDS) dated 10/18/17, indicated R10 had a severe cognitive deficit, rejected care daily, required extensive assistance of 2 staff for bed mobility and transfers, and required extensive assistance of one staff for toilet use and personal hygiene. R10's MDS further indicated R10 was always incontinent of bowel and bladder, had a terminal prognosis, was at risk for pressure ulcers, and currently had a Stage 3 pressure ulcer, though the wound bed had slough (yellow, dead tissue that is stringy or thick and adheres to the tissue on the wound bed), that measured 1.0 centimeters (cm) x 1.0 cm x 0 cm, and had a pressure-reducing device for the chair and bed, and pressure ulcer care. R10's Care Area Assessment (CAA) for cognitive loss and dementia dated 10/13/17, indicated staff must anticipate R10's needs and discuss risk versus benefits related to R10's refusal of cares and treatments with the family and inform the physician if R10's behaviors interfered with activities of daily living (ADLs). R10's CAA for behaviors 10/18/17, indicated R10 had refused cares almost daily and yelled at staff at times during the assessment period, which was not unusual behavior for R10. R10's CAA for pressure ulcers dated 10/13/17, indicated R10 was at risk for pressure ulcers related to incontinence and required extensive assistance with ADLs. R10's pressure ulcer CAA indicated R10 had a pressure reducing cushion in the wheelchair and pressure reducing mattress on the bed, and staff observed skin daily with cares,	F 641	ensure accurate coding of the MDS weekly x 4, monthly x 2 and report to QA committee for further review and recommendations.	

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F 641	Continued From page 5	F 641		

and weekly skin checks by a licensed nurse, with changes in skin integrity reported to the physician (MD) or nurse practitioner (NP).

R10's care plan indicated R10 had an actual pressure ulcer or was at risk, and had an open area to the coccyx (tail bone area) identified on 8/21/17. R10's interventions included a Braden Scale (an assessment tool used to assist in determining an individual's risk for pressure ulcers) per facility policy, occupational therapy evaluation and treatment as indicated for wheelchair positioning (initiated 8/22/17), pressure reducing wheelchair cushion, and pressure reduction/relieving mattress. R10's interventions further directed skin assessments per facility policy, turning and repositioning to include offloading every 2 hours while in wheelchair and R10 was independent with repositioning in bed. R10's care plan revised 3/8/17, directed the use of an air mattress.

A Braden Scale assessment dated 6/23/17, identified R10 was at high risk for skin breakdown with a score of 12.

R10's Weekly Wound Evaluation dated 10/10/17, documented a Stage 3 coccyx pressure ulcer measuring 1.0 cm x 1.0 cm, and was 25% granulation and 75% slough.

R10's Weekly Wound Evaluation dated 10/18/17, measuring 1.0 cm x 0.5 cm and was 100% slough with scant tan drainage without odor. R10's pressure ulcer was documented as improved, though there was 100% slough covering the floor of the pressure ulcer, and no granulation tissue.

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F 641	Continued From page 6	F 641		

R10's progress notes dated 10/20/17, indicated R10 received a new wheelchair. R10's progress notes dated 10/21/17, indicated R10 hurt more in the new wheelchair and by the end of the night, was crying out due to the pain when in the chair. R10's progress notes dated 10/23/17, noted R10 reported to hospice the wheelchair they had provided was uncomfortable and hurt. R10's progress note at that time further indicated R10 had ben refusing to get out of bed due to not wanting to sit in the chair. The hospice aide was to notify the case manager to consider a different chair.

The Weekly Wound Evaluation dated 11/7/17, indicated R10's Stage 3 coccyx pressure ulcer measured 0.9 cm x 0.5 cm and was 100% slough (a pressure ulcer with 100% slough is unstageable per the National Pressure Ulcer Advisory Panel) with scant, tan drainage.

On 1/4/18, at 10:00 a.m. DON stated when a pressure wound is 100% slough, it would be unstageable and verified pressure ulcers should not be down-staged (if Stage 3, it is not documented as less than Stage 3 throughout the healing process) until resolved. The DON stated the wound was improving, but then stated there was an error in documentation if they charted R10's pressure ulcer was improving if it changed from a Stage 2 to a Stage 3. DON stated R10 could turn himself in bed, but would not know to do it and needed reminders. The DON stated her expectation when a resident required extensive assistance with bed mobility, to initiate a repositioning program and verified not all interventions were in place to prevent the development of R10's pressure ulcer, including a turning and repositioning program. The DON

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F 641	Continued From page 7 stated there were many opportunities for repositioning during toileting and other times, though did not know if the repositioning was being done. On 1/4/18, at 3:06 p.m. registered nurse (RN)-B, stated she looked at wounds weekly, and verified a pressure ulcer that has slough in the wound bed would be unstageable and when a pressure ulcer changed from Stage 2 to Stage 3, it is not improving. RN-B verified R10's pressure ulcer came from the wheelchair and that the lift canvas on top of the cushion could decrease the effectiveness of the cushion. RN-B stated they tried different cushions for him. On 1/5/18, at 11:23 a.m. DON verified a pressure ulcer that is slough-filled should be coded on the MDS as unstageable. DON stated the MDS nurse most likely followed skin evaluation documentation. On 1/5/18, at 11:30 a.m. RN-A, stated sometimes she does not get to see the wound and goes by nurse assessment when completing the MDS. RN-A stated she tries to touch base with wound nurse. RN-A verified she was not aware that if the wound bed had slough, the wound would be unstageable. On 1/5/18, at 1:18 p.m. DON stated they do not have a policy for MDS coding, and go by the Resident Assessment Instrument manual.	F 641		
F 657 SS=D	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	F 657		2/23/18

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F 657	Continued From page 8 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 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 ensure the care plan was revised to reflect a current pressure ulcer and interventions for 1 of 4 residents (R17) reviewed for pressure ulcers. Findings include: R17's Diagnosis Report printed 1/4/18, indicated R17's diagnoses included type 2 diabetes, anemia, stage three chronic kidney disease, weakness and heart disease.	F 657	All residents have the potential to be affected if care plan is not updated and revised timely. R17 care plan and aide group sheets updated to list heel ulcer with appropriate staging and care interventions. All care plans and group sheets for residents with current pressure ulcers will be reviewed and completed by completion date to reflect location of wounds and corresponding interventions. All other residents will be reviewed by	

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F 657	Continued From page 9 R17's quarterly Minimum Data Set (MDS) dated 11/2/17, indicated R17 had moderately impaired cognition, was at risk for pressure ulcers, had no current pressure ulcers, and did not have pressure ulcers on the prior assessment. On 11/27/17, R17's Weekly Skin Inspection sheet dated 11/27/17, indicated R17 had an unstageable right heel pressure ulcer. R17's care plan dated 11/1/17, indicated R17 was at risk for pressure ulcers due diabetes, occasional incontinence of bladder, and vascular areas of the lower extremities. The care plan also indicated R17 had a history of resolved pressure areas. The care plan interventions included hourly turning and repositioning, diabetic foot monitoring, a toileting plan, skin care after each incontinence episode and apply barrier cream, a weekly wound assessment, and treatments as ordered. The care plan lacked the identification and interventions for the right heel pressure ulcer. R17's nursing assistant (NA) care guide undated, directed staff to offer every hour repositioning off of buttocks, and to use pillows when in bed for positioning. The NA care guide lacked indication of the right heel pressure ulcer. On 1/4/18, at 2:19 p.m. R17's right heel pressure ulcer was observed during the dressing change with RN-B. R17's heel pressure ulcer measured 4 centimeter (cm) x 4 cm. RN-B described the pressure ulcer as granulation on the top and the rest was eschar. RN-B stated the pressure ulcer was unstageable due to the eschar. On 12/19/17, R17's Weekly Wound Evaluation	F 657	weekly random audits that will be performed for all residents, 8 residents per week, one at a time, for 4 weeks to ensure all residents care plans and group sheets include altered skin areas and location. All care plans and group sheets will be audited with scheduled MDS and significant changes. All trends and patterns triggered by skin alteration will be reviewed at IDT meetings and at quarterly QAPI meetings for sustainable solutions. DON, MDS nurse and/or designee will be responsible person.	

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F 657	Continued From page 10 indicated R17 had a 3 cm by 4 cm Stage 2 pressure ulcer on the right heel. The pressure was cleaned with wound cleanser, skin prep was applied around the open area then covered with a Medihoney dressing (a dressing which draws fluid and dead tissue away from the wound and into the dressing). On 12/26/17, R17's Weekly Wound Evaluation indicated R17 had a 2.5 cm by 4.5 cm unstageable pressure ulcer on the right heel with a change in the wound bed with 100% eschar. On 1/2/18, R17's Weekly Wound Evaluation indicated R17 had a 3 centimeter (cm) by 4 cm, stage four pressure ulcer on the right heel. The pressure ulcer was 25% slough (defined as yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and 75% eschar (a slough or piece of dead tissue that is cast off from the surface of the skin). On 1/5/18, at 11:01 a.m. the director of nursing (DON) was interviewed and verified R17's current pressure ulcer was not on the care plan. The DON stated the pressure ulcer should have been added to the care plan when the pressure ulcer was discovered. A care plan policy was requested and not received.	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		2/23/18

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F 686	Continued From page 11 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess pressure ulcers, implement care plan interventions to prevent worsening of unavoidable pressure ulcers, and provide ongoing monitoring of pressure ulcers for 1 of 4 residents (R10) reviewed for pressure ulcers. In addition, the facility failed to comprehensively assess and provide ongoing monitoring of pressure ulcers to prevent the development and worsening of avoidable pressure ulcers for 1 of 4 residents (R7) reviewed for pressure ulcers. In addition, the facility failed to accurately assess, implement interventions, and provide ongoing monitoring to prevent the worsening of avoidable pressure ulcers for 1 of 4 residents (R17) reviewed for pressure ulcers. This resulted in actual harm for R7, R17, and R10. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable	F 686	All residents have the potential to be affected if assessments, care plans, monitoring, and interventions are not in place. Skin assessments, care plans, monitoring and interventions for R7, R10, R17 have been reviewed, updated and completed. R10 expired 2/7/2018 Updates made to R7 and R17's care plans and interventions will be communicated to staff. Nursing will continue monitoring R7, and R17's skin weekly with weekly wound evaluation assessment. Skin assessments, care plans, monitoring and interventions for all other resident with pressure ulcers and altered skin will be reviewed and updated by correction date. Weekly random audits for all other residents will be performed for all residents, 8 residents per week, one at a time, for 4 weeks to ensure all residents skin integrity is assessed appropriately. All skin assessments will be audited with scheduled MDS and significant changes. All nurses will be educated in wound staging and assessments. The facility will	

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F 686	Continued From page 12 erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.	F 686	continue to seek specialized wound care services to assist with proper assessment, staging, cares and treatment. All trends and patterns triggered by skin alteration will be reviewed at IDT meetings and quarterly QAPI meetings for sustainable solutions. DON, MDS nurse and/or designee will be responsible person.	

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F 686	Continued From page 13 Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible,	F 686		

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this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

R17's Diagnosis Report printed 1/4/18, indicated R17's diagnoses included type 2 diabetes, anemia, stage three chronic kidney disease, weakness and heart disease.

R17's quarterly Minimum Data Set (MDS) dated 11/2/17, indicated R17 had moderately impaired cognition, had no behaviors and rejected cares. R17 needed the extensive assistance of two staff with bed mobility and the extensive assistance of one staff with transfers, locomotion, dressing, toilet use and personal hygiene. R17 did not walk and used a wheelchair for mobility. R17 was at risk for pressure ulcers, had no unhealed pressure ulcers and did not have pressure ulcers on the prior assessment. R17 had pressure relieving devices on the bed and wheelchair.

R17's care plan updated 11/1/17, indicated R17 was at risk for pressure ulcers due to the diagnosis of diabetes, occasional incontinence of bladder and vascular areas of the lower extremities. The care plan further indicated R17 had a history of pressure ulcers that included pressure ulcers on the left and right buttock that resolved on 5/14/17, pressure ulcer on the right gluteal fold that resolved on 7/21/17, and a pressure ulcer on the left gluteal fold that resolved on 8/21/17. The care plan interventions included hourly turning and repositioning, diabetic foot monitoring, a toileting plan, skin care after each incontinence episode and apply barrier cream, a weekly wound assessment and treatments as ordered. R17's care plan lacked

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indication of the right heel pressure ulcer.

R17's nursing assistant (NA) care guide undated, directed staff to offer every hour repositioning off of buttocks. Use pillows when in bed. The guide did not address the heel pressure ulcer.

On 1/4/18, R17 was continuously observed from 7:55 a.m. through 10:35 a.m. At 7:55 a.m. R17 was observed up in the wheelchair in the dining room at the table. R17 had a blue pressure relieving boot on the right foot. At 8:01 a.m. R17 received breakfast. At 8:40 a.m. R17 was taken out of the dining room by nursing assistant (NA)-B and requested to talk to the staff in the business office. At 8:43 a.m. R17 was brought to his room by NA-B. NA-B in was in R17's room for approximately 20 seconds. NA-B did not offer or change R17's position, offload (removing pressure to an area for a period of time), or toilet R17. At 8:53 a.m. NA-B was in R17's room and made the bed. NA-B did not offer or change R17's position, offload or toilet R17. At 8:54 a.m. registered nurse (RN)-A offered R17 an activity and R17 declined. At 9:01 a.m. NA-B and RN-A exited R17's room. NA-B and RN-A did not offer or offload, reposition or toilet R17. At 9:21 a.m. licensed practical nurse (LPN)-B checked R17's oxygen saturation level and did not offer or offload, reposition or toilet R17. At 10:11 a.m. the dietary staff brought R17 a snack of cheese and crackers.

On 1/4/18, at 10:30 a.m. NA-A stated she had not moved or repositioned R17, and R17 was up in the wheelchair when she got to work at 6:00 a.m. NA-B stated she had not moved or repositioned R17 since she had arrived at work at 6:00 a.m. NA-B stated R17 often refused, but verified she

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had not offered to toilet, reposition, or offload R17.

On 1/4/18, at 10:35 a.m. (after no offloading, reposition, or toileting for 2 hours and 40 minutes) R17's skin was observed with NA-B and RN-A. R17 complained of his foot being sore. R17's buttock skin was pink and blanchable. R17 had healed pressure ulcer areas on the right and left sides of the coccyx. The pressure ulcers were covered with superficial shiny skin. RN-A stated R17 had also been incontinent of urine. R17's brief was wet with urine.

On 1/4/18, at 2:19 p.m. R17's right heel pressure ulcer was observed during the dressing change with RN-B. RN-B stated she looked at the resident's wounds weekly. RN-B removed the heel boot, R17's sock and the old dressing. R17's heel pressure ulcer measured 4 cm x 4 cm. RN-B described the pressure ulcer as granulation on the top and the rest was eschar. RN-B cleansed the pressure ulcer, applied skin prep to the surrounding skin, applied the Medihoney dressing, and wrapped the foot with a rolled gauze. RN-B stated the pressure relieving heel boot was to be on at all times and the pressure ulcer was unstageable due to the eschar.

A progress note dated 12/16/17, indicated a NA informed the nurse that R17 had a sore on the heel of his right foot. The heel appeared to have had a blister on it that had already drained. The area measured 2.2 cm by 4.2 cm, with a darker area that was 1.2 cm by 2.2 cm. The area was cleaned with wound cleanser, bacitracin was applied then covered with Mepilex (a foam dressing). A pressure relieving boot was placed on the foot. The nurse practitioner (NP) was

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notified and directed to continue the treatment, change the Mepilex every three days, unless the bandage falls off or drainage leaked through.

R17's Weekly Wound Evaluation dated 12/19/17, indicated R17 had a 3 cm by 4 cm Stage 2 pressure ulcer on the right heel. The pressure was cleaned with wound cleanser, skin prep was applied around the open area then covered with a Medihoney dressing (a dressing which draws fluid and dead tissue away from the wound and into the dressing).

R17's Weekly Wound Evaluation dated 12/26/17, indicated R17 had a 2.5 cm by 4.5 cm unstageable pressure ulcer on the right heel, with a change in the wound bed with 100% eschar.

R17's Weekly Wound Evaluation dated 1/2/18, indicated R17 had a 3 cm by 4 cm, Stage 4 pressure ulcer on the right heel. The pressure ulcer was identified on 12/19/17, and was 25% slough (defined as yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and 75% eschar (a slough or piece of dead tissue that is cast off from the surface of the skin).

On 1/2/18, at 6:46 p.m. R17 was observed up in the wheelchair in his room. R17 had a dressing on the right heel and a blue pressure relieving boot on his foot that went to the knee. R17 did not have a sock on the foot.

On 1/3/18, at 3:46 p.m. R17 was in his room, up in the wheelchair with the blue pressure relieving boot on the right foot.

On 1/4/18 7:00 a.m. R17 was up in the

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wheelchair in the front lobby, with the blue pressure relieving boot on the right foot.

On 1/4/18, at 10:54 a.m. the NA care sheet was reviewed with NA-A and RN-A. The group sheet directed to take R17 to the bathroom every hour and to reposition him every hour.

On 1/4/18, at 2:00 p.m. LPN-A stated R17 usually got up in the wheelchair on the night shift, at approximately 4:30 a.m.

On 1/4/18, at 2:48 p.m. RN-B stated R17 was at risk for pressure ulcers due to being diabetic and needing assistance with mobility. RN-B stated the pressure ulcer was caused from R17 crossing his legs. R17's right heel was the bottom foot with the right heel directly on the floor. R17 did not like to have foot pedals on the wheelchair. RN-B stated the pressure ulcer was avoidable because R17 should have been turned at least every two hours or more frequently due to the current pressure ulcer. Interventions also included a multivitamin, and to have the heel pressure relieving boot on at all times.

On 1/5/18, at 11:01 a.m. the director of nursing (DON) was interviewed and verified R17's current pressure ulcer was not on the care plan, and should have been added to the care plan when the pressure ulcer was discovered. The DON verified there was not an assessment of R17's heels completed until after the pressure ulcer developed. The DON stated R17's risks for pressure ulcers included the need for assistance with mobility, incontinence, noncompliance and diabetes. The DON stated she did not know how R17 got the heel pressure ulcer. The DON thought maybe R17 crossed his feet. The DON

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stated R17 was always wearing shoes and R17's shoes now were not the original ones. The DON stated R17's guardian brought in new shoes for a better fit. The DON verified R17 was to be repositioned every one hour, and the intervention was put into place when R17 started having breakdown. The DON stated everything on the NA care sheets was reflected off the care plan. The DON would expect staff to reposition and or offload as directed by the care plan.

On 1/5/18, at 11:52 a.m. NA-B stated on 1/4/18, she was unable to get everything done because there were a lot of call lights on. NA-B also stated the NA's charting takes a long time to complete, and the facility does not want to have over time so, "Corners are cut."

The facility's Tissue Tolerance Evaluation/Observation policy, dated 6/18/14, directed the tissue tolerance evaluation would be completed when in the chair or bed upon admission, when there was a change in condition that affected mobility, readmission, annually and the development of a pressure related area. Once the resident's turning and repositioning schedule was determined the NA would do a daily skin inspection and the licensed nurse would do a weekly skin inspection to ensure there were no adverse effects to the skin, ensuring the repositioning schedule was appropriate. If a resident refused skin care interventions or treatment a Risk and Benefit form would be completed and reviewed with the resident and/or responsible family member. Documentation would be completed in the medical record. This included updating the care plan and the NA care sheets.

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The facility's Assessment Schedule dated 5/17/17, directed a skin inspection, a wound evaluation for pressure ulcers, and a skin evaluation for other areas of concern would be completed weekly.

R7 stated on 1/3/18, at 9:45 a.m. that he had a sore on his left heel, but did not know how it developed. R7 stated it had been hurting, and when the nurse took off his shoe, there was a big sore. R7 stated he wore a boot on his foot all the time.

R7's Admission Record printed 1/5/18, indicated R7's diagnoses included atherosclerotic heart disease (plaque build-up and narrowing of the arteries), dementia, chronic gout, and heart failure.

R7's quarterly MDS dated 7/14/17, indicated R7 was not at risk for pressure ulcers, required extensive assist for bed mobility, and was frequently incontinent of bowel. The MDS also indicated R7 had no pressure ulcers, and had no pressure relief device in chair or bed.

R7's progress notes dated 9/7/17, indicated R7 was lying in bed with a ring of fluid on the bed sheet near the left foot and a fluid filled blister on the left heel had opened. R7 wore Tenoshapes and had Aquaphor (a skin ointment) applied to lower extremities. The blister was measured at 5 centimeters (cm) x 5 cm with copious amounts of drainage. The blister was dressed and NP was notified.

R7's annual MDS dated 10/10/17, indicated R7

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required extensive assistance for bed mobility and activities of daily living (ADLs), including toilet use and personal hygiene. The MDS indicated R7 was non-ambulatory, and was always incontinent of bladder, and frequently incontinent of bowel. R7's MDS further indicated R7 was at risk for pressure ulcers and had an unstageable pressure ulcer measuring 3.0 cm x 3.5 cm x 0 cm that had eschar (collection of dead tissue) on it, had a pressure reducing device for chair and bed, and received pressure ulcer care.

R7's Care Area Assessment (CAA) for pressure ulcers dated 10/9/17, indicated R7 was at risk for pressure related breakdown, and incorrectly identified R7's skin was currently intact. R7's CAA indicated R7 had edema of lower extremities and staff applied Tenso stockings (compression stockings) every morning and removed in the evening.

R7's care plan dated 9/7/17, identified R7's risk for pressure ulcers and actual development of a blister to left lateral heel related to friction from sandals identified on 9/7/17. Interventions included Braden Scale (an assessment tool used to assist in determining an individual's risk for pressure ulcers) per facility policy, weekly skin inspections, foam heel protector until blister resolved, pressure reduction/relieving mattress, treatments as ordered, supplements as ordered (initiated 10/10/17, for increased nutrient needs related to pressure ulcer and need for healing), protective boot for left foot, and request family to provide proper fitting footwear.

R7's nursing assistant (NA) group/care guide sheet identified fragile skin, blister to left heel, and directed staff to put on Tenoshapes

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(compression stockings), foam heel protector in place at all times until resolved, and to wear no footwear on left lower extremity. R7's group sheet further indicated R7 was independent with bed mobility and to assist with repositioning as needed.

On 1/4/17, at 3:10 p.m. during observation of R7's pressure ulcer, RN-B stated the back of R7's sandal had rubbed and formed a blister, which opened, and then developed eschar. Medihoney was used and it had pulled off the eschar. RN-B stated she was not sure how the eschar developed. RN-B removed R7's dressing and measured R7's left heel pressure ulcer at 1.5 cm x 0.5 cm with 100% granulation. Wound edges had a thin line of slightly macerated skin. R7's pressure ulcer was oval shaped with regular edges. RN-B stated R7's pressure ulcer was avoidable, as his shoes were too tight for his feet, and nursing should have caught that. RN-B stated R7's pressure ulcer went from unstageable to Stage 4, but was now improving.

A facility incident report dated 9/7/17, indicated R7 had a 5.0 cm x 5.0 cm blister on the left lateral heel. R7's incident report indicated R7's blister was fluid-filled, but draining on the bed sheet, so was open at that time. Contributing factors included limited mobility and tight-fitting sandals. Interventions to prevent re-occurrence included a treatment, weekly wound monitoring, offloading of lower extremity and foam heel boot. R7's family would be contacted to provide new footwear.

R7's NP visit progress note dated 9/8/17, indicated R7 had a Stage 2 pressure ulcer of the left heel that had opened from a large blister on the left heel. The NP documented R7's pressure

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ulcer was draining copious amounts. R7 was unaware of the pressure ulcer. The NP further documented the pressure ulcer had developed where R7's skin rubbed on his sandal straps, and was a large blister filled with fluid measuring 2 inches in diameter, and was draining clear fluid. Orders included off load pressure, obtain wider shoes, dressings to left heel.

R7's Order Review Report indicated an order for heel protector to left foot on at all times dated 9/12/17.

R7's physician visit progress note dated 9/13/17, indicated R7 had pitting edema of feet. R7's progress note lacked documentation regarding left heel pressure ulcer.

R7's Weekly Wound Evaluation dated 9/19/17, indicated R7 had a left heel open blister, initially identified on 9/7/17, measuring 4.5 cm x 4.8 cm and was 100% slough with heavy tan drainage that had an odor and macerated edges. R7 had no pain associated with the pressure ulcer at that time.

R7's Tissue Tolerance Evaluation (a tool to assist in determining the ability of the skin and it's supporting structures to endure the effects of pressure with out adverse effects) and Skin Risk Factors assessment dated 9/29/17, indicated R7 was at moderate risk for pressure ulcers. The Tissue Tolerance portion of the test was not completed.

R7's physician orders dated 9/30/17, included orders for heel protector to left foot on at all times, offload pressure left foot/heel blister, obtain wider shoes, spironolactone (diuretic) 50

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milligrams by mouth daily for edema related to heart failure, and monitor pressure ulcer on left heel daily until resolved. R7's Order Review Report indicated R7's treatments for the blister on his left heel were initiated on 9/8/17, and were changed as the status of the pressure ulcer changed.

R7's NP visit progress note dated 10/3/17, indicated R7's left heel unstageable pressure ulcer had increased odor. R10's treatment was changed from Hydrofera Blue (antibacterial foam dressing) to Medihoney (debrides or remove dead, damaged tissue to aid in healing), and documentation indicated R7 may need sharp debridement if Medihoney did not debride the wound.

R7's Weekly Wound Evaluation dated 10/7/17, indicated R7's left heel pressure ulcer was unstageable with 100% eschar, and measured 4 cm x 4 cm. R7's heel pressure ulcer had a moderate amount of tan drainage with an odor present and macerated edges. The plan at that time was to change the treatment to Medihoney to debride the pressure ulcer.

R7's Weekly Wound Evaluation dated 10/10/17, indicated R7's left heel pressure ulcer measured 3 cm x 3.5 cm and was unstageable with 50% slough and 50% eschar, and scant yellow drainage with odor. Wound edges were intact with erythema (redness) and pain was associated with the pressure ulcer.

R7's Weekly Wound Evaluation dated 10/18/17, indicated R7's left heel pressure ulcer measured 3.5 cm x 4.5 cm and was unstageable with 100% slough, and some blood around the edge of the

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wound at 11 o'clock. Wound edges were edematous and pink, and the pressure ulcer had a moderate amount of tan drainage with an odor. The pressure ulcer was to be cleaned with Microklenz (antimicrobial wound cleanser), apply Sure Prep (skin protectant) to wound edges, apply Medihoney dressing, and wrap with kerlix (gauze). R7 had pain with the pressure ulcer and was given oxycodone (narcotic pain medication) as necessary with the dressing change. The Wound Evaluation indicated the wound bed was improving.

R7's NP visit progress notes dated 10/20/17, indicated R7's left heel pressure ulcer was unstageable, and was covered in eschar. The NP documented R7's lower extremities were red, but no swelling.

R7's NP visit progress notes dated 10/24/17, indicated R7's left heel pressure ulcer was unstageable with one inch diameter eschar remaining over pressure ulcer. The NP noted the eschar had softened with the Medihoney, and the wound had an odor. The NP indicated debridement may facilitate healing, and this would be scheduled.

R7's Weekly Wound Evaluation dated 11/1/17, indicated R7's left heel pressure ulcer was Stage 3, measuring 2.3 cm x 3.5 cm x 0.3 cm with 75% granulation (healing tissue), and 25% slough, and a moderate amount of serosanguineous (yellow with a small amount of blood) drainage without odor. Wound edges were pink and rolled, no pain with the pressure ulcer, but controlled with oxycodone as necessary. Treatment changed from Medihoney dressing to Medihoney gel. No change in Weekly Wound Evaluation dated

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11/7/17, MD contacted to discontinue oxycodone before wound treatment due to no pain.

R7's progress notes dated 11/4/17, indicated R7 complained of pain of left heel pressure ulcer, and rated pain at a 6 out of 10.

R7's NP visit progress note dated 11/14/17, documented R7's left heel was healing well with eschar debrided with Medihoney, and granulation was filling. Narcotic pain medication was discontinued as it was no longer necessary prior to pressure ulcer treatment. Progress note noted order for protein powder that had been ordered for wound healing twice daily.

R7's Weekly Wound Evaluation dated 11/22/17, indicated R7's left heel pressure ulcer measured 1.7 cm x 3.0 cm, was documented as a Stage 2, and was 100% granulation without any drainage. R7's wound edges were pink and rolled and R7 had no pain with the pressure ulcer, and was improved.

R7's Weekly Wound Evaluation dated 12/5/17, indicated R7's left heel pressure ulcer dated 0.7 cm x 2.0 cm, was a Stage 2 with 100% granulation, and scant tan drainage without odor and pink, rolled edges.

R7's Weekly Wound Evaluation dated 1/2/18, indicated R7's left heel pressure ulcer measured 1.0 cm x 1.5 cm, was documented as Stage 2 with 100% granulation, without drainage, and edges were pink and rolled. R7 did not have pain with the pressure ulcer.

On 1/3/18, at 4:14 p.m. R7 was observed in his room doorway with the blue pressure relieving

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boot on his left foot. On 1/4/17, at 7:16 a.m. R7 was observed sitting in the dining room with the blue pressure relieving boot on his left foot.

On 1/5/18, at 10:19 a.m. LPN-C stated R7 did not have persistent pain with the pressure ulcer now. LPN-C stated she was not sure if R7 had swollen feet when the pressure ulcer opened, but stated he did not really have edema now.

On 1/5/18, at 10:45 a.m. NA-D stated she did not remember R7 having a lot of swelling in his feet, but stated he used to wear sandals. NA-D stated R7 did not express having pain of his heel and did not resist repositioning.

On 1/5/18, at 11:04 a.m. the DON stated risk assessments should be done upon admission, annually, and with any changes. The DON stated she did not know why there had been such a delay in assessing skin after the identification of pressure ulcers, but would expect the assessments to be done right away when a new pressure ulcer developed. The DON stated R7 did not have edema present at the time he developed the pressure ulcer on his heel. The DON stated R7 propelled himself in his wheelchair, and his sandals did not fit properly. The DON stated R7 did not want the heel protector on at first, but did wear it. The DON stated she felt R7's heel worsened due to the constant pressure from propelling his wheelchair with his feet, and R7 would not stay off of it. The DON stated they do not do a specific analysis for root cause of pressure ulcers, though they do an incident report that looks at risks, interventions, and a summary of investigation. The DON stated R7 should have repositioning every 2 hours.

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On 1/5/18, at 11:36 a.m. RN-A stated R7 did not have a Braden scale done at the time of the MDS in July, so she put him as, "Not at risk," on the MDS, and verified she did not make the determination of risk for pressure ulcers based on limitations in bed mobility and incontinence. RN-A verified R7 was at risk for skin breakdown.

R10's Admission Record printed 1/4/18, indicated R10's diagnoses included demyelinating disease of the central nervous system (condition that results in damage to the myelin sheath or protective covering that surrounds nerve fibers in the brain, optic nerves and spinal cord, causing nerve impulses to slow or stop and neurological problems), progressive multifocal leukoencephalopathy (caused by a virus that destroys the myelin in the brain), spastic paraplegia (paralysis of the legs), and dementia.

R10's MDS dated 6/17, indicated R10 was at risk for pressure ulcers, had no pressure ulcers at that time.

A Tissue Tolerance Observation (a tool to assist in determining the ability of the skin and it's supporting structures to endure the effects of pressure with out adverse effects) dated 6/23/17, indicated R10 tolerated sitting in one position for 2 hours.

A Braden Scale assessment dated 6/23/17, identified R10 was at high risk for skin breakdown.

R10's significant change MDS dated 10/18/17, indicated R10 had a severe cognitive deficit, and rejected care daily. The MDS also indicated R10

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required extensive assistance of 2 staff for bed mobility and transfers, and required extensive assistance of one staff for toilet use and personal hygiene. R10's MDS further indicated R10 was always incontinent of bowel and bladder, was at risk for pressure ulcers, and currently had a Stage 3 pressure ulcer with slough that measured 1.0 centimeters (cm) x 1.0 cm x 0 cm, and had a pressure-reducing device for the chair and bed.

R10's CAA for cognitive loss and dementia dated 10/13/17, indicated staff must anticipate R10's needs and discuss risk versus benefits related to R10's refusal of cares and treatments with the family, and to inform the physician if R10's behaviors interfered with activities of daily living (ADLs). R10's CAA for behaviors 10/18/17, indicated R10 had refused cares almost daily and yelled at staff at times during the assessment period, which was not unusual behavior for R10. R10's CAA for pressure ulcers dated 10/13/17, indicated R10 was at risk for pressure ulcers related to incontinence and required extensive assistance with ADLs. R10's pressure ulcer CAA indicated R10 had a pressure reducing cushion in the wheelchair and pressure reducing mattress on the bed, staff observed skin daily with cares, and weekly skin checks by a licensed nurse, with changes in skin integrity reported to the physician (MD) or nurse practitioner (NP).

R10's care plan revised 8/21/17, indicated R10 had an open area to the coccyx (tail bone area) identified on 8/21/17. R10's interventions included a Braden Scale per facility policy, occupational therapy evaluation and treatment as indicated for wheelchair positioning (initiated 8/22/17), pressure reducing wheelchair cushion, and pressure reduction/relieving mattress. R10's

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interventions further directed skin assessments per facility policy, turning and repositioning to include offloading every 2 hours while in wheelchair and R10 was independent with repositioning in bed. R10's care plan revised 3/8/17, directed the use of an air mattress. R10's care plan further indicated R10 had increased nutrient needs due to wound healing and had an unintentional weight loss related to decline in oral intake. R10's care plan interventions dated 10/10/17, included a nutritional supplement as ordered by the physician, and interventions to attempt to increase R10's nutritional intake. R10's care plan dated 10/16/17, indicated R10 had been admitted to Hospice related to end stage disease.

R10's NA group sheets/care guide for R10, directed staff to turn and reposition every 2 hours, and as necessary. The care guide lacked information on R10's pressure ulcer.

R10's progress notes dated 8/11/17, indicated R10 had a Stage 2 pressure ulcer on the coccyx region, measuring size of a nickel, treated with an unspecified wound care and Mepilex (foam dressing suitable for pressure ulcers), and nursing would continue to treat and monitor.

A NP visit note dated 8/18/17, noted R10 was sitting in a reclining wheel chair during the visit, however, the note lacked documentation of R10's pressure ulcer.

R10's progress notes lacked further documentation regarding the pressure ulcer until 8/21/17, indicating a Stage 2 pressure ulcer had been found on R10's coccyx and measured 8 cm x 10 cm x less than 1 cm deep with scant clear

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drainage without odor. R10's progress note dated 8/21/17, indicated a Mepilex dressing was applied and wheelchair repositioning was initiated.

A facility incident report dated 8/21/17, indicated R10's pressure ulcer was found by a NA during cares. The Stage 2 pressure ulcer was observed by registered nurse. The incident report identified causal factors as refusal of cares, dementia, agitation, and incontinence. Recommendations and interventions identified to prevent re-occurrence were occupational evaluation for wheelchair positioning, turn and reposition every two hours while up in wheelchair, and encourage R10 to understand the risk of refusal of repositioning. The summary of investigative findings on the incident report were: "Orders in place/treatment. Monitor until resolved." The report lacked documentation of a comprehensive investigation.

A Weekly Skin Inspection dated 8/23/17, noted a small pressure ulcer previously documented on R10's coccyx.

R10's Weekly Wound Evaluation dated 9/7/17, indicated a new pressure ulcer on the coccyx, and documented it was identified on 9/7/17. The Weekly Skin Evaluation indicated the Stage 2 pressure ulcer measured 1.5 cm x 1 cm, was 75% granulation (new, healing tissue), 25% eschar (dark dead tissue), and had scant serosanguineous (yellowish with small amounts of blood) drainage without odor. The treatment was identified as Mepilex dressing changed every 3 days and as needed if saturated or if it came loose, cleanse wound with wound cleanser, pat dry and apply Mepilex.

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R10's Weekly Wound Evaluation dated 9/12/17, indicated R10's coccyx pressure ulcer measured 1.2 cm x 0.7 cm and was Stage 2, though was 100% slough, with a scant amount serous (transparent, pale yellow fluid) drainage.

R10's progress notes dated 9/19/17, indicated R10 received Mepilex dressing changes every 3 days and as needed if it became saturated or loose.

A Weekly Wound Evaluation dated 9/19/17, indicated R10's coccyx pressure ulcer identified on 8/22/17, had increased in size and measured 1.2 cm x 1.8 cm and was a Stage 3 with 100% slough. R10's pressure ulcer had a scant amount of tan drainage without odor, and macerated edges.

An NP visit progress note dated 9/22/17, indicated R10 was having increased pain when sitting in chair and documented a current wound on the coccyx. The NP documentation noted R10 had received a new cushion from OT, but continued to have pain, and was squirming in the wheelchair during the visit, and appeared to try to off load the coccyx. The NP's plan was to have OT to re-evaluate for a new cushion, possibly a gel, start a different pain medication, and update if worsens.

A Tissue Tolerance Observation dated 9/22/17, indicated R10's skin remained red, and the test would be re-done at 1 hour. Results after one hour identified a pre-existing sore on the coccyx. It was determined that R10 could be repositioned every 2 hours.

On 9/26/17, NP documented a Stage 2 pressure

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ulcer on R10's coccyx. Hospice was discussed with R10's family. Treatment was documented as Calmoseptine to buttocks every shift.

R10's Weekly Wound Evaluation dated 9/26/17, indicated R10's coccyx pressure ulcer had worsened to a Stage 3 and measured 1.5 cm x 0.5 cm was 25% granulation, and 75% slough, with scant amount of tan drainage without odor, though it was documented as improved. R10's treatment remained the same.

R10's Weekly Wound Evaluation dated 10/10/17, documented a Stage 3 coccyx pressure ulcer measuring 1.0 cm x 1.0 cm, and was 25% granulation and 75% slough. R10's pressure ulcer was documented as improved.

R10's Hospice Skilled Nurse Admission Visit note dated 10/12/17, indicated R10 had a coccyx pressure ulcer, and R10 refused hospice nurse assessment for pressure ulcer at that time. Hospice nurse documented R10 was resting peacefully in the Broda (high back reclining, positioning) chair.

R10's Weekly Wound Evaluation dated 10/18/17, measuring 1.0 cm x 0.5 cm and was 100% slough with scant tan drainage without odor. R10's pressure ulcer was documented as improved, though there was 100% slough covering the floor of the pressure ulcer, and no granulation tissue.

R10's progress notes dated 10/20/17, indicated R10 received a new wheelchair. R10's progress notes dated 10/21/17, indicated R10 hurt more in the new wheelchair and by the end of the night, was crying out due to the pain when in the chair.

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R10's progress notes dated 10/23/17, noted R10 reported to hospice the wheelchair they had provided was uncomfortable and hurt. R10's progress note at that time further indicated R10 had ben refusing to get out of bed due to not wanting to sit in the chair. The hospice aide was to notify the case manager to consider a different chair.

The Weekly Wound Evaluation dated 11/14/17, indicated R10's Stage 3 coccyx pressure ulcer measured 0.5 cm x 0.5 cm and was 100% slough without drainage.

R10's progress notes dated 11/16/17, addressed R10's orders for Mepilex dressing and "cleanse wound with wound cleanser, pat dry, apply sureprep (skin protectant) around the site and apply Mepilex, every 3 day for pressure ulcer."

On 11/28/17, R10's Weekly Wound Evaluation indicated R10's Stage 2 coccyx pressure ulcer measured 0.2 cm x 0.2 cm, was 100% granulation tissue, and had scant serous drainage.

R10's Weekly Wound Evaluation dated 12/12/17, indicated R10's pressure ulcer remained the same as 11/28/17. The treatment was changed to Calmoseptine.

R10's progress notes dated 12/13/17, noted R10's coccyx appeared to be more open, communication to wound nurse to be made.

A Hospice Skilled Nurse Revisit note dated 12/18/17, indicated the Hospice nurse asked about an air mattress request for R10's bed and the facility nurse stated it was not needed at that

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time.

R10's progress notes dated 12/291/7, indicated a message had been left that day with hospice to inquire about an air mattress for R10 due to open wound on coccyx, weight loss and side lying position. Further progress notes dated 12/29/17, indicated the hospice nurse would check on the possibility of providing air mattress.

R10's Weekly Wound Evaluation dated 1/2/18, indicated R10's coccyx pressure ulcer was identified on 8/22/17, was Stage 2 and measured 0 cm x 0 cm, and described as a macerated closed area. Calmoseptine was applied to the area.

A review of R10's progress notes indicated routine skin checks and documentation were initiated and completed, and resident refused cares, treatments, and medications at times, and refused meals, but lacked indication that R10 refused repositioning.

On 1/3/18, at 4:17 p.m. R10 was observed sitting in the dining room in a Broda wheelchair (a tilt and recline wheelchair), with a cushion on his chair with the lift canvas under him and on top of the cushion. R10 was fidgeting and pushing self back in the chair, which was almost fully upright.

On 1/4/18, at 7:40 a.m. R10 was observed sitting in dining room in a Broda chair. R10's mechanical lift canvas was under him and on top of the chair cushion.

On 1/4/18, at 8:38 a.m. R10 had been moved to his room after breakfast, and continued to sit in his Broda chair. R10 was fidgeting in the Broda

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chair, pushing himself back, and then as he let up on the pressure, he slid back down in the chair.

On 1/4/18, at 9:12 a.m. R10 requested to lay down in bed.

On 1/4/18, after R10 was laid down in bed, R10's pressure ulcer was observed with LPN-B. LPN-B observed R10's coccyx, and verified it was currently open with the first one to two layers of skin gone, and no drainage. R10's pressure ulcer measured approximately 0.5 cm x 0.5 cm with white, regular edges. LPN-B left the room to get a registered nurse (RN) to observe R10's pressure ulcer. R10 was observed to roll independently to the right, though required staff assistance to roll further on his side and to roll purposely to other positions during cares.

On 1/4/18, at 9:41 a.m. the DON observed R10's pressure ulcer and stated it was currently a Stage 2 pressure ulcer with 100% granulation tissue, and the wound bed was light pink. The DON verified it had re-opened as it had been closed previously. The DON stated all mattresses in the facility were pressure reduction mattress. The DON verified R10 did not have a pressure relieving mattress. The DON checked R10's wheelchair cushion and verified it was a foam cushion that was provided by hospice, which did not provide pressure relief, and the chair was provided by hospice. The DON verified the Hoyer canvas over the cushion would reduce the effectiveness of the cushion.

On 1/4/18, at 10:00 a.m. the DON stated when a pressure ulcer was 100% slough, it would be unstageable and verified pressure ulcers should not be down-staged (if Stage 3, it is not

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documented as less than Stage 3 throughout the healing process) until resolved. The DON stated when a new pressure ulcer was found, they do an incident report, report to the DON, have an interdisciplinary team (IDT) meeting, and look at the wheelchair cushion. The wound care nurse looks at the injury weekly. The DON stated IDT meeting notes were saved on the computer in collective notes. The DON verified an IDT note was not entered in R10's medical record. The DON stated the nurse practitioner reviewed on 9/22/17, and asked OT to evaluate for a new cushion, and stated R10 had received a new cushion on 8/30/17. The DON verified an assessment to indicate seating duration was not done with the change in R10's cushion, and verified an assessment of seating duration should be done with a new open area or a new surface. DON stated the wound was improving, but then stated there was an error in documentation if they charted R10's pressure ulcer was improving if it changed from a Stage 2 to a Stage 3. The DON stated R10 could turn himself in bed, but would not know when to do it and needed reminders. The DON stated her expectation when a resident required extensive assistance with bed mobility, to initiate a repositioning program and verified not all interventions were in place to prevent the development of R10's pressure ulcer, including a turning and repositioning program. The DON stated there were many opportunities for repositioning during toileting and other times, though did not know if the repositioning was being done. The DON stated repositioning times were assessed with the tissue tolerance test, but that it was not done quarterly.

On 1/4/18, at 10:48 a.m. NA-C stated R10 had always been repositioned every 2 hours, and he

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moved all over in bed during the night, without assistance.

On 1/4/18, at 11:37 a.m. the Hospice RN stated she encouraged turning and repositioning for R10. The Hospice RN stated he did flip and turn all over in bed. The Hospice RN stated she requested an air mattress overlay, and had received the approval for the air mattress the previous day. The Hospice RN stated an air mattress would not have been necessarily ordered previously, as the pressure ulcer had been improving and other things would have been tried first. The Hospice nurse stated it was difficult to get an air mattress for R10's bariatric bed.

On 1/4/18, at 3:06 p.m. RN-B stated she looked at wounds weekly, and verified a pressure ulcer that is slough covered would be unstageable and when a pressure ulcer changed from Stage 2 to Stage 3, it is not improving. RN-B verified R10's pressure ulcer came from the wheelchair and that the lift canvas on top of the cushion could decrease the effectiveness of the cushion. RN-B stated they tried different cushions for him.

On 1/5/18, at 10:50 a.m. NA-D stated R10 resisted repositioning and pushed the lift away. NA-D stated R10 would move himself in bed, but needed assistance when in bed. NA-D stated R10 did not understand the need for repositioning, and they would try to re-approach when necessary.

On 1/5/18, at 10:14 a.m. LPN-C stated R10 resisted cares and repositioning, and did not express pain with the pressure ulcer.

On 1/5/18, at 11:23 a.m. the DON verified a

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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 686	Continued From page 39 pressure ulcer that is slough-filled should be coded on the MDS as unstageable.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		2/23/18

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	245348	A. BUILDING _____ B. WING _____	01/05/2018

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F 690	Continued From page 40 possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure incontinent care services were provided for 1 of 1 residents (R17) reviewed for incontinence. Findings include: R17's Diagnosis Report printed 1/4/18, indicated R17's diagnoses included type 2 diabetes, stage three chronic kidney disease, and heart disease. R17's quarterly Minimum Data Set (MDS) dated 11/2/17, indicated R17 had moderately impaired cognition. The MDS further indicated R17 needed extensive assistance bed mobility, transfers, toilet use and personal hygiene. The MDS also indicated R17 did not walk, used a wheelchair for mobility, was always incontinent of bowel and bladder, and was not on a toileting program. R17's care plan dated 11/1/17, indicated R17 had an alteration of bowel and bladder related to diuretic use, occasional incontinence of bowel and bladder and constipation. The care plan directed staff to offer toileting assistance every hour when awake. R17 used incontinence briefs. R17's nursing assistant (NA) care guide undated, directed staff to offer toileting assistance hourly when awake, and apply barrier cream with each incontinent brief change. The care guide also indicated R17 needed the assistance of one staff for toileting. On 1/04/18, from 7:55 a.m. through 10:35 a.m. R17 was continuously observed. R17 was not	F 690	All residents have the potential affected if bowel and bladder care plan is not followed as stated. R17 care plan and aide group sheets were reviewed and were up to date. Facility will be re-educating staff to focus on toileting and repositioning schedules on their group sheets, and to reach out for support if unable to perform such tasks timely, to ensure residents receive timely care, including for those residents who may refuse cares. Visual and timed random audits will be performed for for R17, as well as all other incontinent residents, and any resident who needs assistance with repositioning by date of correction. Weekly random audits will be performed for all residents, 8 residents per week, one at a time, for 4 weeks to ensure all residents bowel and bladder care plan is being followed. All care plans and group sheets will continue to be audited with scheduled MDS and significant changes. All trends and patterns triggered by bowel and bladder assessments and audits will be reviewed at IDT meetings and quarterly QAPI for sustainable solutions. DON, MDS nurse and/or designee will be responsible person.	

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F 690	Continued From page 41	F 690		

offered or toileted during that time (2 hours and 40 minutes). At 10:35 a.m. R17's incontinent brief was observed with nursing assistant (NA)-B and registered nurse (RN)-A. RN-A stated R17 had been incontinent of urine, and R17's brief was wet with urine.

R17's Bowel and Bladder Data Collection Tool dated 1/31/17, 2/1/17, and 2/2/17, indicated the tool was used as part of the analysis for determining a resident's bowel and bladder status and for developing a toileting plan. On each day the data collection tool had hourly recording of continent or incontinent, if R17 was aware of the urge to void, and asked or indicated the need to use the toilet, bedpan, urinal or commode. The tool also indicated if R17 was incontinent, or if the incontinent brief was slightly wet, mostly wet or the outside clothing was wet. The tool indicated if R17 was prompted to void, if R17 voided a small, medium or large amount, or if R17 refused or did not void. The tool also indicated the activity R17 was in when the incontinence occurred; walking, sleeping, eating or bathing, and if R17 was continent or incontinent of a bowel movement. The data collection tool lacked an assessment of R17's bowel or bladder patterns.

R17's significant change Care Area Assessment (CAA) dated 5/9/17, indicated R17 needed extensive assistance from staff for locomotion, dressing, toileting, bed mobility, grooming, transfers and bathing. The CAA also indicated staff provided peri care after incontinent episodes, and observed R17's skin daily with cares. Weekly skin checks were completed by a licensed nurse with changes in skin integrity reported to the physician or the nurse practitioner.

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F 690	Continued From page 42 On 1/05/18, at 11:01 a.m. the director of nursing (DON) stated R17 was at risk for pressure ulcers due to the need for assistance with mobility, incontinence, noncompliance and diabetes. The DON stated everything on the NA care sheets was reflected off the care plan. The DON would expect staff to offer and toilet R17 as directed by the care plan. On 1/05/18, at 11:52 a.m. NA-B stated on 1/4/18, she was unable to get everything done because there were a lot of call light on. NA-B also stated the NA's charting takes a long time to complete, and the facility does not want to have over time so, "Corners are cut." A care plan and toileting policy was requested and not received. The facility's Assessment Schedule policy dated 5/17/17, directed a three day resident's bowel and bladder routine would be monitored on admission, annually and with a significant change. A bowel evaluation and a bladder evaluation would be completed on before the initial MDS, annually, with a significant change and as needed.	F 690		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Estates at Rush City LLC 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2018

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 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Estates at Rush City LLC care center is a 1-story building with a partial basement constructed in 1967 of type II(111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		

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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 staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 72 National Fire Alarm Code 2010 edition. This deficient practice could affect 35 of 35 residents, as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:00 a.m. to 1:00 p.m. on 01/05/2018, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility's fire alarm test documentation did not contain a detailed account of all fire alarm devices, and did not contain the acceptable obscuration range for each smoke detector on the smoke detector sensitivity test. This deficient condition was verified by a Maintenance Supervisor.	K 345	The facility will utilize the MN Public Safety State Fire Marshall Fire Drill Report going forward for documentation of fire drills. The facility will audit monthly for the next three months the fire drill to ensure that the fire alarm test is working and will document. Maintenance or designee will ensure that a copy of the fire drill documentation is handed into the administrator.	2/23/18

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K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills 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 review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 35 of 35 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 1:00 p.m. on 01/05/2018, during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found: 1. It was revealed that the facility did not conduct 2 day shift fire drill in the first and third quarters. 2. It was revealed that the facility did not conduct 1 evening shift fire drill in the second quarter.	K 712	The facility will conduct in February a fire drill on every shift. Going forward monthly fire drills will be conducted monthly to ensure regulations are met. Maintenance or designee will ensure that a copy of the drill is given to the administrator and the DON.	2/23/18

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K 712	Continued From page 4 3. It was revealed that the facility did not conduct 1 overnight shift fire drill in the second quarter. 4. It was revealed that the facility did not conduct 4 of 12 monthly tests of the DACT. This deficient condition was verified by a Maintenance Supervisor.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 35 of 35 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 1:00 p.m. on	K 901	The facility shall complete annually the healthcare facility risk assessment. Maintenance or designee will ensure that this is updated annually and will be changed as necessary when building needs change.	2/23/18

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K 901	Continued From page 5 01/05/2018, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide any documentation or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced	K 920		2/23/18

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K 920	Continued From page 6 by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (11), National Electrical Code. This deficient practice could negatively affect 10 of 35 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 1:00 p.m. on 01/05/2018, observations revealed that in the Administrator's office and in the west dining room both had multiplex adaptors that were not UL listed, re-locatable nor were they equipped with 15 amp resettable overcurrent protection. This deficient condition was verified by a Maintenance Supervisor.	K 920	The facility shall replace immediately all non-compliant UL adaptors through the facility. Maintenance or designee will ensure that all adaptors are UL compliant on a quarterly basis.	