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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HRFZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROOKVIEW A VILLA CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

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) **12/01/2017**

6. DATE OF SURVEY **01/28/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **104** (L18)

13.Total Certified Beds **104** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date:
Brenda Fischer, Asst Program Mgr 01/29/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist 01/29/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 29, 2019

Administrator
Brookview A Villa Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Number S5186035 and H5186259

Dear Administrator:

On January 28, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Feel free to contact me if you have questions.

Alison Helm

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 29, 2019

CMS Certification Number (CCN): 245186

Administrator
Brookview A Villa Center
7505 Country Club Drive
Golden Valley, MN 55427

Dear Administrator:

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

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

Effective January 26, 2019 the above facility is recommended for:

104 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 104 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HRFZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00112

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245186**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254908000**

3. NAME AND ADDRESS OF FACILITY
(L3) **BROOKVIEW A VILLA CENTER**
(L4) **7505 COUNTRY CLUB DRIVE**
(L5) **GOLDEN VALLEY, MN** (L6) **55427**

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) **12/01/2017**

6. DATE OF SURVEY **12/17/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **104** (L18)

13.Total Certified Beds **104** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Michelle Koch, HFE NE II 01/17/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 01/22/2019 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
January 8, 2019

Administrator
Brookview A Villa Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Number S5186035, H5186258, and H5186259

REVISED LETTER

Dear Administrator:

On December 17, 2018, a standard survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the December 14, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5186258 was found to be unsubstantiated and H5186259 that was found to be substantiated.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 26, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 17, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by June 17, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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,

Alison Helm

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

Electronically delivered
January 4, 2019

Administrator
Brookview A Villa Center
7505 Country Club Drive
Golden Valley, MN 55427

RE: Project Number S5186035, H5186258, and H5186259

Dear Administrator:

On December 14, 2018, a standard survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the December 14, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5186258 was found to be unsubstantiated and H5186259 that was found to be substantiated.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 23, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 14, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by June 14, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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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:

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Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
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St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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,

Alison Helm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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 on 12/10/18 through 12/17/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/10/18 through 12/17/18, a standard survey was completed at your facility by the Minnesota Department of Health. Brookview A Villa Center was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Additionally, complaints H5186259 and H5186258 were investigated. The complaint H5186258 was was not substantiated. The complaint H5186259 was substantiated and deficiencies were issued at F565. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		1/26/19

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

Electronically Signed | 01/10/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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F 558	Continued From page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the appropriate sized shower chair for 1 or 1 residents (R56) who voiced concerns regarding an appropriate sized shower chair. Findings include: R56's admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 had intact cognition and required assistance with bathing. The MDS identified a diagnosis of obesity. During interview on 12/12/18, at 12:44 p.m. R56 stated she had been receiving bed baths instead of a shower because the facility did not have an appropriate sized shower chair for R56. On 12/11/18, R56 received a shower in her wheelchair because the facility continued to not have a large enough shower chair for her, and she really wanted a shower. When interviewed on 12/12/18, at 1:11 p.m. nursing assistant (NA)-G stated there was a couple of sizes of shower chairs but not an appropriate chair for R56 and R56 received bed baths. On 12/13/18, at 12:21 p.m. licensed practical nurse (LPN) - H and the director of nursing	F 558	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. Please accept this plan of correction as the center's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Brookview, A Villa Center respectfully submits this plan of correction and our allegation of compliance as of 1.26.19 1. R56 has been provided appropriate bariatric shower chair. 2. Residents utilizing bariatric shower chairs have been reviewed to ensure accommodation of shower chair needs. 3. Nursing staff have been re-educated regarding accommodating shower chair needs and process to obtain shower chairs. 4. DON/Designee will audit 3 showers per week to ensure appropriate shower chairs	

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F 558	Continued From page 2 (DON) were interviewed. LPN-H stated the facility was obtaining a super bariatric shower chair for R56 and R56 had agreed to bed baths in the meantime. The DON stated the facility needed the appropriate equipment to care for R56. DON thought a larger super bariatric shower chair had been been ordered after R56 had admitted, but would need to check on the status of the order. During observation on 12/13/18, at 12:19 p.m. a standard shower chair was located near shower room, a super bariatric shower chair was not located in the building. When interviewed on 12/14/18, at 10:49 a.m. DON stated after talking with the administrator the the super bariatric shower chair had not been ordered for R56 because staff did not inform management that the current bariatric shower chair in the building was not the proper size for R56. The undated facility policy Facility Accommodation of Needs and Preferences and Homelike Environment Guideline identified it was the practice of the facility to identify and provide reasonable accommodation of resident needs.	F 558	are in use. Audit results will be reviewed at QAPI.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565		1/26/19

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F 565	Continued From page 3 (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficient resolution to continued food concerns raised for 6 of 6 residents (R10, R16, R39, R49, R50, and R57) reviewed for grievances. Findings include: RESIDENT R16's quarterly Minimum Data Set (MDS) dated	F 565	1.R10, R16, R39, R49, R50 and R57 have been interviewed regarding food likes/dislikes and tray card will be updated. RD/DSM will meet with the identified residents to assure food choices are being met. 2.All residents will be assessed for food preferences, including request for any scheduled snack on admission, quarterly and CC reviews, tray tickets will be	

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F 565	Continued From page 4 9/28/18, identified R16 had intact cognition. During interview on 12/10/18, at 2:36 p.m., R16 stated it "took forever to get food and it is not good because it is not prepared right; chicken is usually overcooked, vegetables are boiled to death, it is too high in salt, fat, and sugar, and they rarely serve fresh fruit." If R16 were to be offered fresh fruit, it was usually an orange that should have been thrown away. The facility does offer an alternative menu but were often out of food items. R16 had requested to have 1% milk but the overseeing facility corporation would not supply it. R16 would not be offered an evening snack. R16 confirmed he recently filed a complaint and the facility is aware of his concerns. On 12/11/18 at 9:26 a.m., R16 still had not received a breakfast tray that was ordered shortly after 8:00 a.m. During an interview on 12/11/18 at 3:45 p.m., R16 stated he finally received his breakfast that morning at approximately 9:50 a.m. Staff came into his room at 1:45 p.m. to see what he wanted for lunch. Staff were usually done serving the noon meal around 12:00 p.m.. He was not sure why the ordering of his meal had been delayed. He told staff it was too late to eat at that time. During observation and interview on 12/12/18 at 8:37 a.m., staff took R16's breakfast order. R16 had not received his breakfast tray until 9:38 a.m. R16 would order oatmeal for breakfast because it developed a layer over the top that held in the heat so it was still somewhat warm when he received it.	F 565	updated as food preferences changes. Food Council will meet monthly. Meal satisfaction surveys will be completed. Menu will be adjusted according to results of survey. Procedure for timely delivery of meals will be reviewed and adjusted to assure timely arrival of meals 3.Dietary Staff will be educated on following recipes. Staff will be educated on snack policy/procedure. Staff will be educated on the policy/procedure of reporting grievances and follow up/resolution. 4.Dietary Manager/ Designee will perform 3 audits a week to assure compliance with timely arrival of meals, snacks and meal satisfaction.	

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During interview on 12/12/18 at 1:14 p.m., R16 stated he had ordered the apple dessert around noon and had yet to receive it.

During interview on 12/13/18, at 8:45 a.m., R16 stated he ordered his breakfast tray around 8:00 a.m. but had not received it until 8:59 a.m..He continued to voice complaints about the meal services as he received the prior evening's meal tray at 6:50 p.m., 50 minutes after he ordered it. The meal consisted of one piece of breaded fish, one piece of corn bread, and seven tater tots. The only thing "edible was the tater tots".

Review of R16's progress notes indicated he voiced concerns and complaints several times. On 8/31/18, staff noted R16's dissatisfaction with the food. R16 was subsequently often supplemented with food brought in to the facility by his family. On 9/7/18, R16 was documented stating, "I am losing weight because I don't like the food". R16 complained of the "flavor of food". "I just don't like the stuff you serve sometimes". On 10/9/18, staff documented R16 reported oven roasted potatoes were hard and his mashed potatoes were cold the other day. He preferred 1% milk. Staff reviewed milk options at that time with resident and offered instead skim, 2%, whole or thinning of his 2% milk. "Broccoli pieces are steamed to death." R16's family continued to bring in food. There was no mention if staff had resolved his grievances or had investigated his claims of weight loss .Leave in the blue. It adds to the complaint.

RESIDENT MEETING
During resident meeting with the survey team on 12/12/18, at 10:59 a.m., R10, R39, R49, R50, and R57 were in attendance. R57 stated he does not

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eat the meals at the facility, he buys his own. The food was not always served at the correct temperature and the facility frequently ran out of alternative menu items. R10's hamburger was "pink" the other day and undercooked. R10 received a snack the other night. It was the first one she had received in the evening since her admission. R49 received a snack the night before, which was the first one he received in about two weeks. R39 would like some grapes for an evening snack. All residents agreed and expressed concerns meals were served late all of the time, no matter how many staff were working. Afternoon and evening snacks were not being delivered routinely. All residents acknowledged they knew how to file a grievance. R57 stated, "what good does it do, they don't do anything about them". They stated follow-up was not completed by the facility and resolutions to their concerns were not reported back to them.

Resident council meeting minutes from June to November 2018 were reviewed. The 6/5/18, residents minutes identified residents wanted to see more fresh fruit, meat salad, and soup. On 7/26/18, residents were adjusting to the new menu changes and they liked different things offered than on the menu. On 9/6/18, the AD documented afternoon and evening snacks were not being passed out; and noted it would be brought to nurses's attention. On 11/6/18, resident council minutes indicated the Mac-N-Cheese was too mushy, chili was to spicy, more meat was requested at breakfast, beef fritters were too hard to eat, there were too many dumplings in the chicken-N-dumpling soup, and the bacon and sausage was greasy. There was no indication if the resident concerns or complaints from all three floors, had been

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addressed or resolved by facility staff.

Interview on 12/14/18, at 10:36 a.m., with the registered dietician (RD) revealed there had been discussions about food at resident council. The facility had a food committee to discuss concerns related to food. There were complaints that week about not getting the type of snack the residents wanted, but was unaware residents were not receiving a bedtime snack. An assortment of snacks go out to each floor every evening. It was up to nursing staff to pass the evening snack at approximately 7:00 p.m. to residents that have a dietary order for snacks; All other residents must ask staff for a snack in order to receive one as it was not routinely offered. RD was aware of complaints about alternative items on the menu not being available. It was her understanding the facility was increasing the amount of food ordered to ensure all who requested a alternate meal would receive one. RD would visit residents to discuss any concerns she was made aware of.

Later interview on 12/14/18, at 11:16 a.m. RD stated she had reviewed resident concerns about food preferences, but there was no indication the resolution to these concerns were documented in writing.

During an interview on 12/14/18, at 4:06 p.m. nursing assistant (NA)-K stated there were enough staff to pass evening meals. Evening staff were responsible to pass snack and document who received snack in the medical record.

During an interview on 12/14/18, at 4:08 p.m. NA-L stated evening staff were responsible for passing evening snack and documenting in the

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F 565	Continued From page 8 medical record. Not all residents received snacks. NA's pass meal trays. NA-L felt the typical wait time for a resident to receive their meal was 10-15 minutes. Things were more manageable right now because the resident census was low. During an interview on 12/14/18 at 11:44 a.m., the director of nursing (DON) stated her expectation was for scheduled snacks to be delivered on time. All other residents knew there were snacks available upon request. The dietician was responsible to determine which residents needed scheduled snacks. Review of the 11/28/17, Grievance Guideline policy indicated the grievance official was to complete a response to the resident or resident's representative which included the date of grievance/concern, summary of grievance, investigation steps, the resolution and outcome and actions taken.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		1/26/19

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F 578	Continued From page 9 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to explain end of life code status in a manner the resident understood for 1 of 1 residents (R7) who stated they did not understand what the code status options were. Findings include: R7's annual Minimum Data Set (MDS) dated 9/16/18, identified R7 had intact cognition and diagnoses of emphysema (lung disease), chronic obstructive pulmonary disease (lung disease),	F 578	1.Facility has explained end of life code status options with R7 and the medical record has been updated accordingly. 2.All Residents have been educated regarding code status options. Additionally, Residents' code status will be reviewed upon admission, annually, quarterly and with change of condition to ensure the medical record reflects the resident's preference. 3.Staff was educated on how to explain choices relating to advance directives.	

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F 578	Continued From page 10 atrioventricular block (abnormal heart rhythm), peripheral vascular disease (reduced blood flow to the limbs), diabetes, atrial fibrillation (irregular heart beat), severe obesity (overweight), muscle wasting and atrophy, and high blood pressure. R7's Code Status Elective Form dated 9/11/18, was signed by R7 and witnessed by the social services designee (SSD)-A. The form identified in the event R7 would experience a cardiac or cardiopulmonary arrest, witnessed or unwitnessed, staff were not to intervene as he was marked Do Not Resuscitate (DNR). R7's care plan dated updated 9/25/18, identified R7 as a full code, meaning they want any resuscitation measures implemented. During interview on 12/12/18, at 1:58 p.m., R7 stated if his heart stopped beating, he would want the facility to resuscitate him with CPR and the use of "paddles". He did not wish to be "hooked up to a lot of tubes". R7 signed some forms, but stated he had not understood the medical terms that were used. On 12/13/18, at 12:21 p.m. social services designee (SSD)-A stated R7 was definitely interviewable and able to make his own decisions. SSD-A reviewed R7's medical chart and stated R7 was a DNR per R7's Code Status Election form dated 9/11/18. SSD-A co-signed the form after witnessing R7 sign the DNR status. SSD-A was responsible for informing the resident and reviewing the code status, but couldn't explain the reasoning for the discrepancy. Code status and/or advance directive care planning was discussed upon admission and reviewed every year. SSD-A stated they described to the	F 578	Education included how to teach patient what these choices mean and to update additional parties (MD, NP, DON, HOSPICE, etc.) If patient exhibits signs of confusion due to choices of advance directives 4.DSS/Designee will perform 3 audits that will be completed weekly to ensure residents understand and the medical terms related to the code status options. Audit results will be reviewed in QAPI.	

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F 578	Continued From page 11 residents the difference between full resuscitation including CPR, feeding tubes, or anything to keep them alive and a DNR, which meant means nothing would be done. If a resident chose CPR then it meant a full code including tube. On 12/13/18 at 12:28 p.m., the SSD-A stated they had a conversation with R7 about his code status wishes. SSD-A used the acronyms DNR, CPR, and POLST (Provider order for life sustaining treatment) when asking R7 his end of life wishes. R7 stated "you lost me. I hate all these initials, what do they mean? Explain it in plain English." SSD-A then explained to R7 what the acronyms meant and details were then explained to R7. R7 stated his wishes were "I want CPR but if they have to put a tube down my throat to keep me alive, I don't want that". SSD-D indicated that he understood R7's wishes and would have him sign a new form to accurately reflect the code status he wanted. Review of the 11/28/17, Villa Healthcare Resident Rights policy indicated the facility would provide information to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		1/26/19

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for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's

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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 582	Continued From page 13 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate notification related to expected charges for services for 1 of 1 residents (R564) who's family voiced concerns about the cost of stay. Findings include: R564's facesheet indicated admission date to the facility was 12/6/18. R564's primary insurance was private pay. During interview on 12/11/18, at 9:23 a.m. family member (FM)-B stated R564 had confusion and was R564's decision maker. FM-B expressed concern R564 had been in the facility for several days with no discussion regarding the cost for her stay and how billing would be processed and what FM-B would be responsible to pay. During interview on 12/14/18, at 1:11 p.m. business office manager (BOM) stated she was going to meet with FM-B today on 12/14/18, to go over the admission agreement. This had not yet been done and was typically done within 48 hours of admission by the admissions coordinator. The facility did not have an admission coordinator and the duties were split between herself and the administrator. BOM stated she was behind in going over admission agreements with residents. R564's unsigned admission agreement was	F 582	1.R564's FM-B has been met with by BOM. Charges have been explained and Admission Agreement has been completed. 2.All residents currently in house have been provided copies of current rate sheet effective January 1st, 2019. All new residents will be provided with current rate sheet. Facility will ensure that all new residents are provide with an estimated daily rate upon admission. 3.BOM/Admissions or designee responsible for proper completion of Admission Agreements has been educated on how to properly complete Admission Agreement. All staff has been educated of who to contact if residents or family members have questions about the rate of payment or services provided. 4.Administrator/ designee will audit 2 Admission Agreements weekly for proper completion of Admission Agreement including an initial rate for basic care services. Audit results will be reviewed in QAPI.	

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F 582	Continued From page 14 provided which contained a statement indicated the initial rate for basic care services had been estimated and indicated below, However, the daily rate did not contain a dollar amount for the daily rate to be billed, but hand written was "unk" (unknown). During interview on 12/14/18, at 4:15 p.m. vice president of operations (VPO) stated a rough estimate of the daily rate should be pulled together and provided on the admission agreement until the Minimum Data Set was completed and then they could provide family with an accurate daily charge according to the case mix level with the case mix estimate. As a consumer it was important to know daily rate for services which should be done within 48 hours of admission. At 4:30 p.m. VPO returned with additional information that there was a private pay daily charge of $306.10 until the MDS was completed. This would be expected to be explained to the responsible party. During follow-up interview on 12/14/18, 4:45 p.m. BOM stated unknown was placed as the estimated daily rate because she was not aware there was a daily rate to use until the MDS was completed. The facility policy Facility Admission Guideline dated 11/28/17, identified the facility would provide proper notice of the cost of services offered and given to the resident before or at the time of admission.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		1/26/19

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F 583	Continued From page 15 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal privacy by unnecessarily exposing body parts during provision of care for 1 of 4 residents (R56) observed who were dependent upon staff for personal cares.	F 583	1.Resident 56 is being provided privacy during personal cares. 2.All resident who require assistance with personal cares are being provided privacy during those cares. 3.Staff have been re-educated regarding providing privacy during personal cares	

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F 583	Continued From page 16 Findings include: R56's admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 was cognitively intact and required extensive assistance with activities of daily living (ADLs). During observation of cares on 12/12/18, at 8:53 a.m. nursing assistant (NA)-G removed R56's bedding. R56 was wearing a hospital gown. NA-G folded the gown down and exposing and washing R56's breast. When NA-G was finished washing and drying R56's breast NA-G completely removed the gown exposing R56's breasts, abdomen and perineal area. R56's remained exposed as NA-G finished washing R56. At 9:01 a.m. R56 was assisted into a clean gown, R56 had remained exposed for seven minutes after her gown was removed and a clean gown had been put on, no longer exposing her upper torso and breasts and perineal area.. When interviewed on 12/12/18, at 9:27 a.m. NA-G stated he should have covered R56's exposed skin during cares for her privacy but had not done so. When interviewed on 12/12/18, at 9:30 a.m. R56 stated the staff always pulled down her gown all the way while giving her a bed bath. When interviewed on 12/13/18, at 12:32 p.m. director of nursing (DON) stated staff were expected to only uncover and expose areas necessary to clean and then should cover the exposed area immediately. This was important to ensure a residents privacy during cares.	F 583	4.DON/Designee will audit 5 residents per week to ensure privacy is being maintained during cares. Audit results will be reviewed at QAPI	
F 636	Comprehensive Assessments & Timing	F 636		1/26/19

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F 636 SS=D	Continued From page 17 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 636		

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F 636	Continued From page 18 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure care areas triggered for comprehensive assessment using the Resident Assessment Instrument (RAI) process were completed for 3 of 3 residents (R4, R25 R56) who's Care Area Assessments (CAA)'s were not assessed. Findings include: R4's annual Minimum Data Set (MDS) dated 3/15/18, identified R4 was cognitively intact. The MDS indicated R4 was at risk for development of pressure ulcers. R4's Pressure Ulcer/Injury Care Area	F 636	1.R4, R 25, and R56 have been reviewed and a comprehensive assessment has been completed according to their functional capacity. 2.All residents who have had a comprehensive assessment completed on or after 10/1/2018 have been reviewed to ensure a comprehensive assessment has been completed and updated if indicated. Comprehensive assessments will be completed ongoing upon admission, annually or significant change including a comprehensive assessment of triggered care areas accordingly. 3.MDS coordinator CAA education provided on 12/21. CAAs will be	

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F 636	Continued From page 19 Assessment (CAA) dated 3/15/18, identified the nature of problem/condition as "LTC (long term care) resident with diagnoses which include paraplegia, chronic pain, muscle spasm, anemia, and intracranial injury. Resident at risk for falls, pressure ulcer. Incontinent of bowel, has s/p (suprapubic) catheter in place. Requires assist with ADL's and cares, staff assists with bed mobility, mechanical transfers, toileting personal hygiene. Non-ambulatory, uses a w/c to move around. Independent in eating with set up. Staff assist with turning and repositioning, on check and change program - has pressure reducing mattress and cushioned chair, free from pressure areas and falls." R4's Pressure Ulcer/Injury failed to completely and accurately identify all of R25's environmental factors, address medication that increase risk for pressure ulcer/injury development, or include history of healed pressure ulcer/injury. In addition the CAA inaccurately indicated R4 had an altered mental status. Input from resident/family was left blank. The CAA did not provide a comprehensive analysis of the findings or a description of impact of the resident's problem in order to identify a rational for a care plan decision. R4 had additional CAA's including activities of daily living (ADL) function, urinary incontinence and indwelling catheter. Reviewed CAA's identified the same paragraph for the nature of the problem/condition as R4's Pressure Ulcer/Injury CAA. In addition, the reviewed CAA's also failed to address input from resident and or family and did not include a comprehensive analysis of their findings; and the ADL function CAA failed to indicate a reason for individual ADL	F 636	completed per RAI Manual and Villa RAI Policy for all comprehensive assessments. Comprehensive assessments will be completed upon admission, annually and significant changes to ensure a comprehensive, accurate, standardized, reproducible assessment is completed per the residents functional capacity. The assessment will include direct observation and communication with the resident as well as communication with direct care staff. 4.DON/ Designee will audit 2 residents per week to ensure comprehensive assessments and CAA triggers are comprehensive and accurate. Audits will be reviewed at QAPI.	

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problems.

Further, R4' had a care plan focus for limited physical mobility related to paraplegia, revised on 12/9/18, indicating R4 required a walker and stand by assist to ambulate.

R25's annual MDS dated 7/17/18, identified R25 had severe cognitive impairment. The MDS indicated R25 was at risk for development of pressure ulcers.

R25's Pressure Ulcer/Injury CAA dated 7/18/18, failed to identify R25's environmental factors, diagnosis of Peripheral Vascular Disease, and history of healed pressure ulcer/injury. Input from resident/family was left blank. The CAA did not provide a comprehensive analysis of the findings or a description of impact of the resident's problem in order to identify a rational for a care plan decision.

R25's Pressure Ulcer/Injury CAA identified the nature of problem/condition as "Resident is at risk for pressure ulcers due to incontinence and bed mobility. Resident has diagnosis of Dementia, is dependent on staff for bed mobility and toileting. Staff assist with all incontinent cares. Skin assessment is done weekly on bath days. Resident on cushioned w/c and pressure relieving mattress. Resident is free from pressure areas."

R25 had additional CAA's for communication, activities of daily living (ADL) function, urinary incontinence and indwelling catheter, and nutrition status, all of which failed to address input from resident and or family and did not include a comprehensive analysis of their findings. Further,

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the ADL function CAA failed to indicate reason for individual ADL problems.

R56 admission Minimum Data Set (MDS) dated 11/23/18, identified R56 was cognitively intact with a history of falls prior to admission.

R56's fall CAA dated 11/26/18, failed to identify R56's history of falling, laboratory tests, and environmental factors. Input from resident/family was left blank. The CAA did not provide a comprehensive analysis of the findings or a description of the resident's problem to identify a rational for a care plan decision.

R56's fall CAA identified the nature of problem/condition as "Residents diagnosis include morbid obesity, anxiety, depression, lymphedema, anemia. Resident has a wound vac (negative pressure wound dressing) in place for cellulitis. Resident has limited mobility and requires extensive assistance with transfers, bed mobility due to pain in leg and morbid obesity. Resident rates pain at 7/10 and is currently receiving PRN (as needed) narcotics, nursing monitor for pain and effectiveness of pain medication. Resident is incontinent of bowel and bladder, at risk for pressure ulcer, staff does weekly skin assessment, Braden, apply barrier cream for incontinence episode. Resident has no history of pressure ulcer and nursing will continue to promote skin integrity. Resident had broken tooth on regular diet, denies chewing or mouth problems a this time. Will refer to dietician an or dentist if problems should arise. Resident is at risk for falls, had fall prior to hospitalization. Resident has not had a fall since admission, in physician ordered OT/PT (occupational/physical therapy). Will continue to care plan with goal to

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F 636	Continued From page 22 return resident back to prior level of independence, minimize risk for skin break down, falls, and to manage pain." R56 had additional CAA's for activities of daily living (ADL) function, urinary incontinence and indwelling catheter, dental care, pressure ulcer/injury and pain, all identified the same paragraph for the nature of the problem/condition as R56's fall CAA. Further there was no input from resident and or family for these CAA's. Also there was no comprehensive analysis of their findings. When interviewed on 12/13/18, at 1:06 p.m. director of nursing (DON) stated she expected any CAA's which triggered be completed, further a comprehensive assessment was important to create a person centered care plan. DON was not aware CAA's had not been completed. The MDS 3.0 RAI Manual v 1.16 dated 10/18 identified "The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care."	F 636		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		1/26/19

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F 677	Continued From page 23 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with activities of daily living for 4 of 6 residents (R27, R15, R25, R23) who were dependent upon staff for their cares. Findings include: INCONTINENCE CARE: R27's quarterly Minimum Data Set (MDS) identified diagnoses which included hemiplegia (partial paralysis affecting left, non-dominant side) dementia and muscle weakness. The MDS indicated R27 had severely impaired cognition, was unable to walk and identified R27 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, dressing, toileting, and personal hygiene. R27's 10/16/18 quarterly bowel and bladder assessment indicated R27 had functional bladder incontinence related to immobility and impaired physical mobility, secondary to a CVA (stroke). R27's care plan dated 10/19/18, identified an alteration in urinary continence related to dementia, and a history of significant CVA, bed bound status and total dependency with all cares. The care plan directed staff to check and change R27 every two hours and PRN (as needed.) During continuous observations on 12/13/18, from 5:44 a.m. to 9:11 a.m. R27 was lying in his bed without being checked for incontinence a total of 3 hours and 27 minutes:	F 677	1.R27, R15, R25, and R 23 are being provided the necessary daily cares for the dependent residents to maintain good nutrition, grooming, and personal and oral hygiene. 2.All Resident's dependent on staff for cares are being provided assistance with their ADL's to maintain good nutrition, grooming, and personal and oral hygiene. 3.Education has been provided to nursing staff regarding provision of daily cares for the dependent residents including incontinence, oral, nail, and bathing cares. 4.DON/designee to complete random audits of 4 dependent residents weekly to ensure residents are receiving the necessary daily cares. Audits will be reviewed at QAPI.	

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-5:44 a.m., R27 was lying on his back in bed, dressed in a gown, a sheet was pulled down to below his waist. R27 appeared asleep, but had audible sound of lung congestion.
-5:59 a.m., there were no changes to R27's position.
-6:22 a.m., licensed practical nurse (LPN)-A entered the room, unwound the oxygen tubing and placed the cannula into R27's nares.
-6:37 a.m., nursing assistant (NA)-E entered R27's room, looked at R27 and saw he was asleep, then pulled the sheet up, covering R27's chest, and exited room without checking R27's brief or repositioning him.
-6:42 a.m., LPN-E peeked in on R27, nasal cannula on his face
-7:01 a.m., and again at 7:14 a.m., there were no changes to R27's position.
-7:30 a.m., R27 began making intermittent incoherent verbalizations, and social services designee (SSD)-A enters the room, asked "Do you need anything, [R27]?" R27, continued to make incoherent verbalizations, and SSD-A exited the room.
-7:41 a.m., LPN-E entered R27 room "Please keep your oxygen on," re-adjusted the nasal cannula, exited
-7:47 a.m., LPN-E entered R27's room, checked his placement of his oxygen nasal cannula and exited.
-8:18 a.m., LPN-E returned and placed an oxygen mask on R27 and started a nebulizer treatment. No changes were made in R27's position.
-8:29 AM, an unidentified staff entered R27's room, drew a blood sample from R27. R27's nebulizer treatment was still running
-8:46 a.m. LPN-E entered room, removed his mask, and placed his nasal cannula tubing back

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on,, then exited the room without repositioning him or checking his brief.
-9:11 a.m. NA-E entered R27's room briefly, then exited his room without repositioning or checking him for incontinence.

On 12/13/18, at 8:58 a.m. LPN-C stated she was unaware R27 had not had morning cares and was not checked or changed, repositioned, or off-loaded since approximately 5:45 a.m. LPN-C immediately responded "that was not ok and I will get my people to help him right away."

Continued observation on 12/13/18 of R27 in his room identified at 9:11 a.m. NA-E entered R27's room, quickly exited and advised LPN-C he was going to get more help. At 9:20 a.m., NA-F entered the room along with registered nurse (RN)-A and began morning cares for R27. At 9:24 nurse consultant (NC)-A also entered the room to participate in morning cares for R27, which included cleaning his face and upper body, and personal cares. NA-F removed and changed R27's brief and stated it contained a moderate amount of urine. There was a minimal amount of smeared BM (bowel movement) contained in the soiled brief. R27 was finally repositioned.

When interviewed on 12/13/18, at 9:45 a.m. NA-E stated he went into R27's room "to check on" him shortly after the start of the shift, "maybe around 6:30 a.m.," but did not reposition or check his brief. NA-E stated he covered up R27 at that time. He was going to help R27 with cares but indicated he thought another aide came in to help R27. NA-E acknowledged he had not checked, changed, or reposition R27 since the start of the morning shift that day.

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When interviewed at 12:34 p.m. on 12/13/18, NA-F stated she "freshened up R27 this morning." NA-F stated she was not originally assigned to work with R27, and did not known when R27 had been last checked for wetness or was repositioned. She changed R27 around 9:15 a.m. that morning. R27 and a number of other residents on the floor needed to be repositioned at least every two hours. At that time, staff were to check residents for incontinence.

When interviewed at 1:08 p.m. on 12/13/18, registered nurse (RN)-A stated R27 was a total assist for all ADLs. R27 was incontinent of bowel and bladder. R27's toileting program was to check and change, meaning staff were to go into R27's room and physically check R27's brief for wetness. At that same time staff were to reposition or offer to reposition. She would expect R27 and any other resident who needed assistance with ADL's be checked and repositioned.

When interviewed on 12/14/18, at 8:35 a.m. the director of nursing (DON) stated it was her expectation a resident's toileting was not only completed but be done in a timely manner. Routine care was an expectation of staff and a standard of care. "We [the facility] have staff who are trained and certified. That is their job."

ORAL CARES:
R15's quarterly MDS dated 9/23/15, identified R15 had severe cognitive impairment and required extensive assistance with personal hygiene. Diagnoses included cerebral vascular accident (CVA) or stroke, and dementia.

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R15's care plan updated 9/22/18 identified a potential for oral/dental problems as evidenced by resident resisting assessments and refusals, secondary to her cognitive The care plan directed staff to provide mouth care preferable BID (two times a day) at AM and HS (morning and night) as resident allows. If R15 initially refused, staff were to re-approach as often as possible and document refusals.

During observation beginning at 6:55 a.m. on 12/12/18 , NA-E began morning cares for R15. After R15 was washed, personal care provided and she was dressed at 7:14 a.m., NA-E summoned another aide to transfer R15 from the bed into her wheel chair. At 7:22 a.m. NA-E and NA-B transferred R15 from her bed into the wheel chair. NA-B exited the room, but NA-E remained in the room and made R15's bed. NA-E retrieved a brush from R15's dresser drawer near the sink, ran water on it, and combed her hair. At 7:27 a.m., NA-E pushed R15 in her wheel chair transporting her into the dining room for the breakfast meal. NA-E had not offered or provide R15 with oral cares.

After breakfast , at 9:22 a.m. NA-E wheeled R15 from the dining room to the day room area, adjacent to the dining room for an activity. R15 remained there until 10:10 a.m. when NA-E took her to her room and provided incontinence care. NA-E had not offered or provided oral care to R15. At 10:23 a.m. R15 was wheeled back to the activity.

When interviewed at 1:24 p.m. on 12/12/18, NA-E identified R15 was dependent on staff to assist with oral cares. NA-E stated she had not completed oral hygiene for R15. R15 should have

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had her teeth brushed or NA-E should have used a toothette. It was her first day here. "I guess they got missed."

When interviewed at 3:41 p.m. on 12/12/18, NA-D stated R15 should have oral cares done at least twice a day as all residents were. NA-D had not worked in the morning, but said oral care should have been part of R15's routine morning care. "It needs to be completed."

When interviewed on 12/13/18 at 1:15 p.m. registered nurse (RN)-A expected oral cares be offered and completed. If oral cares were offered but refused, staff were to attempt later.

When interviewed on 12/14/18, at 8:35 a.m. DON stated it was her expectation for oral cares be completed.

NAIL CARES:
R25's quarterly MDS dated 10/17/18, identified R25 had severe cognitive impairment and was dependent on staff for personal hygiene. Diagnoses included cerebral palsy (neurological disorder affecting movement and motor skills), dementia and a history of traumatic brain injury.

R25's care plan dated 10/18/18, identified an ADL self-care performance deficit related to limited mobility. Staff were to clean and trim R25's nails on bath day and as necessary.

During observations on:
(1) 12/10/18, at 5:41 p.m., R25 was sitting in her wheelchair watching television in her room. R25 had long finger nails with visible black debris under them.
(2) 12/11/18, at 11:01 a.m. and again at 4:01 p.m.

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R25 continued to have visibly long finger nails with black debris under them.
(3) 12/12/18, at 7:07 a.m., while providing morning care, nursing assistant (NA)-A failed to perform hand hygiene on R25's hands and fingers.
(4) 12/13/18, at 11:42 a.m., R25's nails remained long with visible black debris under them.

On 12/13/18 at 12:21 p.m., licensed practical nurse (LPN)-J observed R25's fingernails and stated R25 had visibly long fingernails with black dirt-like debris underneath. LPN-J stated R25 often refused care and when R25 refused care staff were to document the refusals. LPN-J reviewed R25's treatment record and found no documentation staff provided any nail care to R25, or that she had refused to allow staff to perform nail care.

R25's Behavior Symptoms log from 11/13/18 through 12/13/18, indicated no documentation to support R25 had been refusing nail care, resulting in her unkempt nails.

During interview on 12/14/18, at 11:44 a.m. the DON stated she expected nail care be provided weekly, on bath days, and as needed. Refusal of cares were to be addressed on the resident's care plan and documented in the medical record. If cares were refused, reattempts should have been made. Staff should ask for assistance from other staff if needed.

BATHING:
R23's quarterly MDS dated 10/11/18, identified R23 had intact cognition and required extensive to total assistance from staff with activities of daily

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living (ADL) and bathing.

Documentation Survey Report (CNA documentation of cares) reveals R23 should get a bath every morning and evening shift. A shower is documented once and a bed bath twice in October, two bed baths were documented in November, and two bed baths documented in December.

During interview on 12/12/18, at 9:11 a.m. NA-B stated R23 only received bed baths and the staff did not wash R23's hair.

R23's undated Resident Bath Schedule identified R23 was scheduled for a bath or shower weekly on Tuesday mornings.

On 12/13/18, at 7:52 a.m. R23's hair was visibly greasy and unkempt. R23 had a foul sweaty odor. R23 stated he was going to get a hair cut that day. R23 stated the facility staff had not washed his hair for four months. He would have the barber cut his hair once per month just to make sure he got his hair washed. R23 had never received a shower or bath in the facility, but was instead given bed baths and his hair was not washed during the bed baths.

On 12/13/18, at 11:23 a.m. R23 continued to have visibly greasy hair and had a foul odor. R23 had approximately 1/4 inch facial hair and his nails were long with a dark substance underneath the nails. R23 stated staff did not complete any personal cares that morning with the exception of providing him with a clean gown.

On 12/13/18, at 2:53 p.m. R23 was lying in bed. R23 remained in the hospital-type gown, with long

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F 677	Continued From page 31 facial hair present, greasy hair, and body odor. A resident and family Christmas party was scheduled to start at 4:00 p.m.. R23 indicated he would "really like to go" but only if staff would perform his basic cares. R23 stated it was the third day he remained in bed due to not having cares completed by staff. On 12/14/18, at 11:23 a.m. R23 was dressed , however R23's fingernails continued to have a dark substance and debris underneath them. R23 could not remember the last time he had a bath or shower. R23's face remained unshaven, his hair was greasy and uncombed. R23 stated no one had offered to brush his teeth that day. "They [staff] usually don't". Being clean and kempt was very important to him. "I used to shower and brush my teeth once a day but it is a rare thing now". A strong body odor remained. During interview on 12/14/18 at 12:10 p.m. RN-A stated her expectation was morning and evening cares were to include residents being washed up, have their teeth brushed, hair combed and dressed in personal clothing. R23 was to receive at minimum of one shower every week. A policy on ADL's was requested, but none was provided.	F 677		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 678		1/26/19

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F 678	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to accurately document resident's code status throughout the medical record for 2 of 2 residents (R25, R7) reviewed for inconsistent advanced directives. Findings include: R25's quarterly Minimum Data Set (MDS) dated 10/17/18, indicated R25 had severe cognitive impairment. The Diagnosis Report, dated 12/13/18, indicated diagnoses including vascular dementia without behavioral disturbance, epilepsy, cerebral palsy, dysphagia, and history of traumatic brain injury. R25's Code Status Elective Form, dated 11/13/18, indicated R25 was DNR (do not resuscitate). R25's Face Sheet, printed on 12/13/18, indicated R25 was a full code, meaning they want any resuscitation measures implemented. R25's Order Summary Report, identified active orders as of 12/13/18, as full code. R25's care plan revised 10/18, identified R25 as full code. Although R25's elective form identified DNR, the orders, face sheet and care plan all identified full code, which was a discrepancy from R25's initial election. R7's admission Minimum Data Set (MDS) dated 9/16/18, identified R7 had intact cognition.	F 678	1.R25 and R7 CPR status have been reviewed and the medical record updated accordingly. 2.All residents medical records regarding CPR have been reviewed and updated as needed 3.Education was provided to Licensed nursing staff and social services to ensure Code status/advance directives forms match and coincide with residents' wishes 4.Social Service/designee to complete 3 random audits weekly to ensure CPR status form coincides with the medical record and plan of care. Audits will be reviewed at QAPI.	

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Diagnoses included emphysema (lung condition causing shortness of breath), chronic obstructive pulmonary disease lung disease), atrioventricular block (block of impulses in the heart), peripheral vascular disease (reduced blood flow to the limbs), Diabetes (chronic condition that affects the way the body processes blood sugar), atrial fibrillation (irregular heart beat), severe obesity (overweight). muscle wasting and atrophy, hypertension (high blood pressure).

R7's Code Status Elective Form dated 9/11/18, was signed by R7 and witnessed by SSD-A. The code status identified in the event R7 experienced a pulse less, cardipulmonary arrest, (witnessed or unwitnessed), requests DNR status.

R7's care plan revised on 9/15/18, identified R7 had an advance directive which included; "I wish for full code with no intubation." R7 expressed these wishes with his family present. Interventions directed staff to refer to advance directive documents for care preferences and directives and to review advance directives and CPR (cardiopulmonary resuscitation) consent form upon admission, annually, quarterly, significant change in status and as needed during the resident care conference.

R7's December 2018, Medication Administration Record (MAR) and December 2018, Treatment Administration Record (TAR) identified R7's code status as do not resuscitate (DNR)

R7's Physican Order Summary Report dated 12/13/18, identified a DNR status for R7.

Physician progress notes electronically signed by

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NP-C (nurse practitioner-certified) 11/28/18 identified R7 had a code status of DNR/DNI (do not intubate).

R7's medical record and care plan had conflicting information. According to the care plan R7 would want his heart started and physician orders and code status listed directed staff to not revive and allow a natural death.

During an interview on 12/12/18, at 1:24 p.m., licensed practical nurse (LPN)-F stated she was new and did not know where to find a resident's code status.

During an interview on 12/12/18, at 1:27 p.m., LPN-A stated she would check for a resident's code status on the computer or in the chart; LPN-A also stated checking the computer would be quicker because they are usually close to one.

During an interview on 12/12/18, at 1:31 p.m. LPN-D stated he would look in the first part of a resident's chart to determine their code status.

During an interview on 12/12/18, at 1:35 p.m., LPN-G stated they can look for a resident's code status in the electronic health record (EHR) or in the resident's chart. In an emergency LPN-G stated if she was in a resident's room then she would look in their EHR because it would be closer. LPN-G also stated if the emergency was in the dining room, then she would look in the chart because that would be closer.

On 12/12/18, at 1:58 p.m. R7 stated if his heart stopped beating he would want to be resuscitated with CPR and the use of "paddles", but did not want to be hooked up to a lot of tubes. R7

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F 678	Continued From page 35 indicated that he had signed "some forms" to change his code status to DNR, but did not want to be intubated. During interview on 12/13/18, at 11:33 a.m. LPN-D stated if he found someone unresponsive and not breathing, he would look in the front of the paper chart at the advanced directive for a code status. He would then call for assistance, call 911, and start CPR if the code status indicated CPR should be given. LPN-D observed R7's code status in the hard chart and stated R7 would not receive CPR because R7 had identified a DNR code status. R7 would be allowed to die without attempts to restart R7's heart. During interview on 12/14/18, at 9:58 a.m. the director of nursing (DON) stated the facility staff had found some inconsistencies in resident code status' in August 2018. Staff went through all resident's charts to "clean them up" so they matched the care plan and had done it again the evening prior after the discovery of R7's discrepancy. The facility policy Advance Directives and Care Planning Guidelines revised 3/2/18, Resident choices will be incorporated into treatment, care, and services. For a resident to exercise his or her right to make informed choices designated personnel will assist with defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, in a language that the resident can understand, as appropriate.	F 678		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		1/26/19

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F 679	Continued From page 36 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess life enrichment and activities needs for 2 of 2 residents (R27, R51) reviewed in the sample for activities, who were dependent upon staff for opportunities to participate in activities. Findings include: R27's quarterly Minimum Data Set (MDS) identified diagnoses which included dementia, hemiplegia (affecting left, non-dominant side) mood disorder and depression. The MDS indicated R27 had severely impaired cognition, and identified R27 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, and that R27 did not walk. R27's care area assessment for activities dated 7/19/18, indicated R27 had little interest or pleasure in doing things. The CAA indicated "Resident yells out and curses at staff, does not like 1:1 visits, gets upset." Section F of the Minimum Data Set (MDS) dated 7/18/18,	F 679	1.R27 and R 51- needs for life enrichment have been reassessed and care plans updated accordingly. 2.All residents life enrichment needs have been reviewed and reassessed as appropriate. Residents will continue to be assessed for LE needs upon admission, quarterly, and significant change reviews, with care plans updated quarterly. LE will provide ongoing programming to support residents choice in activities and to support their well-being. 3. Education was provided to Life Enrichment regarding comprehensive assessments and activity needs for assessments. Education was provided to LE to ensure implementation of the assessments and care plan accordingly. 4. LNHA will audit 3 residents per week to ensure Recreation assessments and care plans coincide with patient needs for independent and group activities; including ensuring programming identified is implemented accordingly. Results of the audits will be reviewed at QAPI.	

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indicated a family interview for routines and activities was not done. The staff assessment for daily and activity preferences indicated "No" to the following: reading book/newspapers/magazine; doing things with people; and spending time away from nursing home; but indicated "Yes to the following: listening to music, keeping up with the news, participating in favorite activities, and spending time outdoors.

R27's care plan for activities indicated R27 had little or no activity involvement related to cognitive limitations, (dementia). R27's care plan goal: "Likes to watch TV/movies when up in the chair, and enjoys music activities for short period of time." The care plan directed staff to provide activities calendar monthly, and respect residents' right to refuse activities.

During observation at 2:55 p.m. on 12/10/18, R27 was observed lying in his bed. R27's room was illuminated by the natural light coming in through the window. A TV was on a at the foot of R27's bed, but currently was turned off. R27's room was austere; the walls on R27's side of the room were bare. There was no radio or music player in R27's room. During subsequent observations on 12/10/18 at 2:55 p.m. and later at 6:44 p.m., R27 was also seen lying in bed; the TV remained off.

Intermittent observations on 12/11/18, indicated the following:
-9:05 a.m., R27 lying in bed, head elevated, dressed in gown, intermittently turning head and looking, some unintelligible verbalizations, the TV is not on
-10:40 a.m., R27 remains in bed, no changes.
-3:41 p.m., R27 continues in bed, head elevated,

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intermittent verbalizations,
-4:12 p.m. same, no changes

Intermittent observations on 12/12/18 indicated the following:
-at 6:37 a.m.,R27 was in bed in his room, asleep, room quiet, no TV
-7:47 a.m. no changes, R27 eyes open, turns head to respond to "good morning"
-9:50 a.m., no changes, TV off, no outside stimulation
-12:01 p.m. R27 continues lying in bed, no changes.
-1:38 p.m., no changes

On 12/10/18, at 3:00 p.m. interview attempted with R27, when greeted and smiled, R27 turned face, opened eyes, acknowledgement of presence, but offered no verbal response. Subsequent interviews attempted with R27 on 12/11/18, at 10:40 a.m. and on 12/12/18, at 12:01 p.m. with R27 responding by looking at surveyor, but providing no verbal or spoken feed back.

When interviewed at 6:54 p.m. on 12/10/18, family member (FM)-A stated many years ago R27 had a stroke and now simply didn't do much. FM-A stated R27 was totally dependent on staff and could do nothing for himself. FM-A stated R27's big activity for the week now is his shower "I think he gets that once a week." FM-A stated R27 was not into games like bingo and would refuse many activities, "he kept more to himself. FM-A stated R27 did respond to TV. FM-A stated unfortunately, since changing jobs, he visited R27 infrequently at the nursing home. FM-A stated the staff were the ones who had to get R27 involved in activity.

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When interviewed at 3:37 p.m. on 12/12/18 nursing assistant (NA)-D stated he had not seen R27 involved in any kind of activities, for several months. NA-D stated R27 does sit up in his chair "when we can get him there" but that most of the time R27 stays in his bed. NA-D stated when upon the chair he would have the TV on, and thought he might watch a movie, but would not want to stay up in the chair for a long-enough time. NA-D said he was not aware of any one-to-one program for R27, or if R27 liked music, or if he just liked having a radio on in his room. NA-D stated he did not recall R27 having his TV on, at least lately. NA-D NA-D looked in R27's room and was not able to find any activity schedule or calendar, and also stated R27 did not have a radio in his room.

When interviewed at 12:24 p.m. on 12/13/18, licensed practical nurse (LPN)-E said R27 was spending his life lying on his back in his room and stated he definitely needs some stimulation. LPN-E stated she hears all the time that R27 or other resident "refuses" and when I hear refuses, "I go bananas." LPN-C state success with R27 was "in how you approach [R27]." LPN-C stated while R27's condition may be sad, we still have to go and give our effort and try. LPN-E thought staff were trying to include him in some kind of activity, and stated he would have the TV on. LPN-E stated she has not seen the TV used much of late, and did not know about other activity interventions presently for R27.

When interviewed on 12/13/18 at 12:34 p.m., NA-F talked about R27's activity involvement and stated she has conversed with R27, one-to-one, but you had to find him in a "mood" and talk in a calm way. NA-F stated he may converse about

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football. NA-E stated R27 would sit up in the chair, but did not tolerate that well. NA-E stated this past September or October she took him outside of his room to where R27 could actually look outside of the building. NA-E stated she did not think R27 got that opportunity much NA-E stated R27 did not like to socialize with others or in groups, as that seem to cause him more anxiety, which controlling that seemed key to having success with working with R27.

During interview at 3:06 p.m. on 12/14/18 the life enrichment director (LED) stated R27 was challenging individual who did not like to come out of his room. The LED stated R27 had communication barriers and it was not easy to know what R27 wanted. The LED stated R27 rarely attended activities, based on his not wanting to get out of bed. The LED acknowledged the most recent resident preferences assessment was dated 8/21/17, and was completed by a prior activity director. The LED also stated he was not able to contact R27's family to solicit information for an assessment, which would also come from staff. The LED reviewed the documented interactions with R27, and acknowledged there were few documented in the computer. When asked if R27's current care plan interventions were implemented, the LED stated R27 had seen to become more upset and requesting the TV be turned off when that was tried. The LED also stated the facility no longer allowed posting of an activity calendar on resident walls due to fire safety. The LED could not say if R27 had a current activity schedule in the room, which was more useful for staff.

The director of nursing (DON) was also present during the interview, and stated the IDT

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(interdisciplinary team) reviewed each long-term care resident on a quarterly basis, assessing all aspects of that person, including life enrichment. The DON stated we'll have to attempt and try to complete a more thorough assessment of R27 for activities. The DON stated that the resident's refusals should be documented and acknowledged, and further that the facility will continue to attempt to find meaningful ways to engage R27. The DON stated "I get that" as part of our assessment of R27's activity needs. The DON stated it was her expectation re-assessment of R27's life enrichment, like other care needs, be completed at least quarterly and "updated as we go."

Although R27 had been a resident at the nursing home since, R27 lacked comprehensive life enrichment or activities assessment. The assessment lacked more current information about R27's interests, lifestyle, work history, hobbies, art, music, and his current demeanor and assessment of therapeutic needs for activities. Further, the assessment id not identify what interventions and approaches had been attempted, whether or not successfully, Consequently, the lack of thorough assessment hindered development of a resident-centered care plan, with measurable goals, and interventions that when implemented, allow resident to meet his goal.
R51's admission Minimum Data Set (MDS) dated 10/29/18, identified R51 was cognitively intact. The MDS identified R51's activity interests of books, magazines, listening to music and keeping up with the news as being important to R51.

R51's Life Enrichment History and Assessment Short Stay dated 10/29/18, identified R51 liked to

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be social and would like the newspaper and books to be provided.

R51's Preferences for Customary Routine and Activities assessment dated 10/29/18, identified it was very important for R51 to listen to music and had preferred Ecuadorian music. The assessment further identified it was very important for R51 to do favorite activities which included painting, cleaning and cooking.

R51's care plan dated 12/2/18 lacked an activity care plan.

On 12/11/18, at 9:00 a.m. R51 stated he had nothing to do in the facility and just sat on his bed all day. R51 stated his interests were playing cards, listening to music and had liked to use his computer to watch videos, listen to music from his home country, and to talk with his family using social media. There no were books, magazines, computer or newspapers in R51's room.

During interview on 12/12/18, at 1:11 p.m. nursing assistant (NA)-G stated he had not seen R51 attend activities. NA-G stated R51 did not attend activities to his knowledge and spent most of his time in his room.

During observation on 12/12/18, at 1:24 p.m. activity staff was in the second floor dayroom playing Brazilian beach music for three residents. R51 was not in attendance.

R51's medical record did not identify activities R51 was invited to or participated in.

During interview on 12/13/18, at 8:39 a.m. life enrichment director (LED) stated typically R51

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F 679	Continued From page 43 was invited to activities and would hang around the activity, but did not participate. The short stay assessment was done but the activity care plan was missed for R51. There were two computers available for residents in common area and LED stated he had shown theses to R51. During interview on 12/13/18, at 8:46 a.m. licensed practical nurse (LPN)- H stated R51 occasionally came out of his room to attend activities. During follow-up interview on 12/13/18, at 2:03 p.m. LED stated there was no activity records on invitations to activities or on activity attendance for the last couple of months for R51. LED stated he was the activity department except for one activity aid that helped out on the weekends. LED was behind on tracking activities of the residents in the facility. A policy regarding activities was requested, but none was provided.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 684	1.R25 is being provided with	1/26/19

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F 684	Continued From page 44 review, the facility failed to ensure compression sleeves were used as ordered by the physician for non-pressure related skin conditions for 1 of 1 residents (R25) reviewed for non- pressure skin concerns. Findings include: R25's annual Minimum Data Set (MDS) dated 7/17/18, identified R25 had severe cognitive impairment and was dependent on staff for activities of daily living (ADL's). R25's MDS further indicated there was one venous or arterial ulcers present. R25's Diagnosis Report, dated 12/13/18, identified diagnoses including peripheral vascular disease vascular dementia without behavioral disturbance, epilepsy, cerebral palsy, and history of traumatic brain injury. R25's care plan revised 10/18, identified R25 had a history of cellulitis (skin infection) to the right leg and wounds to the right lower extremity. Interventions included elevate leg when in bed, apply skin protectant, and monitor skin for breakdown. R25's skin/wound note(s) in the electronic medical record (EHR) dated 10/24/18, indicated R25's right leg wound was healed and scarred area was open to air. R25's provider order dated 10/25/18, identified R25's right leg was healed. The order also directed staff to place tubi grips (light compression sleeve) , on in the morning and off at night. The order failed to indicate a location for the tubi rips. R25's undated nursing assistant care sheet did	F 684	compression sleeves (tubi grip) per MD order. 2.All residents with orders for compression sleeves (tubi grip) have been reviewed and are being provided with compression sleeves 3.Education has been completed to nursing staff regarding application of tubi grip (compression sleeves) and provision of treatment and care per MD order 4.DON/designee to audit 3 residents per week for application of tubi grip and/or provision of treatment and care per MD order. Audits will be reviewed at QAPI.	

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not identify tubi-grips for R25.

During observation on 12/10/18 at 2:14 p.m., R25 was not in her room but cloths were piled on the floor under the sink area, two tubi rips were lying on top of the clothing.

During observation on 12/10/18, at 5:14 p.m. and 6:14 p.m. R25 did not have the tubi grips in place. During an additional observation on 12/11/18, at 4:01 p.m. R25 did not have tubi grips in place.

During observation of morning cares on 12/12/18, at 7:07 a.m., nursing assistant (NA)-A stated R25's right lower extremity was red in color with no open areas, and had a scabbed area to the outer ankle bone. NA-A applied a tubi grip to R25's right leg and stated it was for swelling,

During observation on 12/13/18 at 11:42 a.m. R25 was seated in her wheelchair in the dining area, waiting for lunch. R25 had a tubi grip to her right leg only.

R25's December 2018, Treatment Administration Record (TAR) indicated an original order for "tubi grips on AM and off HS every day and evening shift," which were signed off by staff, as being completed.

On 12/13/18, at 11:50 a.m., licensed practical nurse (LPN)- G, who was the nursing supervisor, stated R25 had an order for tubi grips to both lower legs, but sometimes R25 would refuse them. LPN-G further stated if R25 refused, it would be for both tubi grips and not just one. LPN-G observed R25 and stated she had one tubi grip on the right leg. LPN-G stated the other tubi- grip must have been in the laundry or

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F 684	Continued From page 46 something and she would get another one and apply it. LPN-G stated the tubi-grips were not identified on R25's care plan or nursing assistant care sheet.. LPN-G also stated she would add bilateral lower extremities to the order and care plan. The facility policy Skin Management Guideline dated 11/28/17, included guidelines for treatment of pressure ulcers and lower extremity ulcers (arterial, venous, neuropathy/diabetic, or mixed). The guideline includes evaluating/re-evaluating interventions and modify the plan of care. The guideline further indicates to update the care plan for skin integrity and nursing assistant care cards with skin concern, appropriate risk factors, and interventions as appropriate.	F 684		
F 686 SS=D	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- (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 provide appropriate	F 686	1.R4's wound is being assessed, dressed/packed according to plan of care	1/26/19

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F 686	Continued From page 47 wound care and adequate repositioning for 2 of 4 residents (R4 and R27) who had or were at risk for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often includes undermining and tunneling.) R4's quarterly Minimum Data Set (MDS) 9/11/18, identified he was cognitively intact and at risk for pressure ulcers, with no current pressure ulcer. R4 was dependent on staff for toileting, repositioning and transferring and was incontinent of bowel. Interventions included a pressure reducing device in the chair and in bed. The MDS identified R4 had a diagnosis of paraplegia (paralysis of lower half of the body). R4's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 3/15/18, indicated environmental risk factors for PU, immobility and potential cognitive impairment at times [related to his traumatic brain injury]. R4's physican orders signed 12/5/18, identified the staff were to use dermal cleanse to irrigate the ulcer, pack the ulcer with calcium alginate (debrided wounds to remove dead tissue) and cover the ulcer with island dressing twice a day to the "isheal wound" for wound tunneling at the 1 o'clock location. Further, the physican orders	F 686	per physician's orders and the wound status has improved. R27 will continue to be turned and repositioned according to their plan of care. 2.All residents at risk for skin impairment are assessed through facility risk assessment and interventions are added according to the risk level. Residents at high level of risk are turned and repositioned according to their care plan. Residents with wounds are assessed and treated per MD order. 3.Education has been completed with licensed nursing staff regarding appropriate wound care including packing of a wound. Education has been completed with nursing staff regarding repositioning according to the plan of care. 4.DON/designee to complete 5 audits weekly of at risk residents to ensure adequate repositioning is in place according to the plan of care. DON/designee to audit wound care of 3 residents per week to ensure appropriate wound care according to the plan of care and MD orders. Audits will be reviewed at QAPI.	

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identified an order on 2/26/18, to limit R4's sitting to no more than 20 minutes at a time and for staff to document any refusals.

R4's care plan dated 12/9/18, R4 had Activities of Daily Living (ADL) self-care performance deficits related to his paraplegia. Staff were directed turn and reposition R4 every 2 hours, and as needed; avoid positioning R4 on his coccyx for extended periods of time; treatment of skin breakdown including use of a pressure relieving mattress, pressure relieving and use of a pressure relieving cushion in his wheelchair. R4's care plan did not identify any pressure ulcers care or treatment.

On 12/13/18, at 7:17 a.m. R4's dressing change was observed with licensed practical nurse (LPN) -D, for R4's pressure ulcer (PU) on the right gluteal (buttock) fold. R4's dressing was not intact and was located in R4's incontinent product. LPN-D stated staff had reported the dressing was not intact and was going to complete wound care. LPN-D used a dry washcloth to wipe around the PU and sprayed wound cleanser inside the wound. He then cleaned the PU using 4 by 4 gauze. LPN-D completed this process three times. LPN-D then cut a piece of calcium alginate to fit and placed it inside the wound bed. LPN-D did not pack the PU as directed by the physician orders. A bordered foam was placed to cover the dressing. During the dressing change R4 became incontinent of stool (BM) and the foam dressing became soiled. LPN-D removed the dressing once again from the wound. LPN-D did not remove his soiled gloves and perform hand hygiene the clean dressing and applied it to the pressure ulcer. The observation identified R4 had a stage 4 pressure ulcer.

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On 12/13/18, at 7:45 a.m. LPN-D reviewed the physicians order and stated the order directed staff to pack R4's PU with calcium alginate. LPN-D stated he was unaware R4's pressure ulcer needed packing as there was no tunneling of the ulcer; although, the wound was deep.

During interview on 12/13/18, at 7:47 a.m. registered nurse (RN)-A (the facility wound nurse) stated the pressure ulcer dressing change LPN-D completed did not follow physician orders and wound was not appropriately packed. RN-A stated due to the depth of the wound, it would take more than one layer of packing to appropriately pack R4's PU.

During interview on 12/13/18, at 8:35 a.m. director of nursing (DON) and nurse consultant (NC)-A stated their expectation was staff needed to appropriately document and pack R4's PU as indicated in the the physician's order. R4 had complained to the DON several times about not being repositioned in a timely manner by staff.

R27's quarterly Minimum Data Set (MDS) identified diagnoses which included hemiplegia (affecting left, non-dominant side) dementia and muscle weakness. The MDS indicated R27 had severely impaired cognition, and was unable to walk. The MDS also identified R27 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, dressing, toileting, and personal hygiene. A comprehensive skin assessment summary, dated 10/16/18, identified

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R27 has the potential for pressure ulcer in all high pressure areas related to bed confinement/immobility, secondary to CVA (cardio-vascular accident or stroke) with resulting hemiplegia. The assessment indicated that staff provide R27 with assistance to turn/reposition at least every 2 hours, as as needed or requested. R27's Braden scale (tool used to determine pressure ulcer risk) dated 7/23/18, identified "low risk", and indicated R27 had very limited mobility, was bedfast, and had the potential for a problem with friction and shear. The care area assessment (CAA) for pressure ulcers, dated 7/23/18, identified R27 as at risk for pressure ulcer because she needed extensive ADL assistance for bed mobility and was frequently incontinent of bowel and bladder.

R27's care plan (CP) identified the potential for alteration in skin integrity and contained the goal to have intact skin, free of redness, blisters or discoloration. The CP directed staff to follow the mobility plan of care, and among numerous interventions to assist R27 "to provide assistance to turn/reposition at least every 2 hours, and as needed or requested.

During continuous observation from 5:44 a.m. to 9:11 a.m. on 12/13/18, , R27 was lying in his bed without being offered or assisted to reposition or be checked for incontinence, 3 hours and 27 minutes. During this time, the following observations were made:

-at 5:44 a.m. R27 was lying on his back in bed, dressed in a gown, a sheet was pulled down to below his waist. R27's beard is untrimmed, and hair somewhat matted and disheveled. R27's head of bed was elevated about 30 degrees, and

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F 686	Continued From page 51 his call light cord lay on top of the mattress. R27 was not wearing his nasal cannula, but rather the cannula and tubing were wrapped around the oxygen canister in the room at the foot of the bed. R27 appeared asleep, but had audible sound of lung congestion. -5:59 a.m., no changes -6:22 a.m. licensed practical nurse (LPN)-A entered the room, unwound the oxygen tubing and placed the cannula into R27's nares, and placed the tubing around his ears -6:37 a.m. nursing assistant (NA)-E entered R27's room, looked at R27 and saw he was asleep, then pulled the sheet up, covering R27's chest, exited room with door two-thirds of the way open -6:42 a.m. LPN-E peeked in on R27, nasal cannula on his face -7:01 a.m., no changes in position -7:14 a.m., no changes in position -7:30 a.m. R27 began making intermittent verbalizations, and social services designee (SSD)-A enters the room, asked "Do you need anything, [R27]?" R27, with eyes open, continued to make verbalizations, and SSD-A exited -7:41 a.m. LPN-E entered R27 room "Please keep your oxygen on," re-adjusted the nasal cannula, exited -7:47 a.m. LPN-E entered R27's room, checked placement of the nasal cannula and exited -8:18 a.m., LPN-E places mask on R27 and starts a nebulizer treatment, no changes in position, -8:29 AM, unidentified staff entered room, draws blood sample from R27, nebulizer still running -8:46 a.m. LPN-E entered room, removed mask and put oxygen tubing back on R27, then exited -9:11 a.m. NA-E entered room, appearing to want to begin cares, exits room	F 686		

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-At 8:58 a.m. the surveyor told LPN-C that R27 had not had morning cares and had not been repositioned or off-loaded since approximately 5:45 this morning. LPN-C immediately responded and stated "that was not ok and I will get my people to help him right away."
-9:11 a.m. NA-E entered R27's room, and quickly exited and to LPN-C he was going to get more help

At 9:20 a.m., NA-F entered the room along with registered nurse (RN)-A and began morning cares fro R27. At 9:24 nurse consultant (NC)-A also entered the room to participate in morning cares for R27, which included cleaning his face and upper body, and provision of perineal cares. At 9:27 NA-F removed and changed R27's brief and stated it contained a moderate amount of urine. There was a minimal amount of smeared BM (bowel movement) contained in the soiled brief. When repositioned to facilitate peri cares, R27's skin was inspected. R27's groin area, buttocks, coccyx and right and left hips. skin exhibited no reddened creases and intact. RN-A assessed R27's skin as "without redness, no open areas, with a marking of BM."

When interviewed on 12/13/18 at 9:45 a.m., nursing assistant (NA)-E stated he went into R27's room "to check on" him shortly after the start of the shift , "maybe round 6:30 (a.m.)," but did not reposition or check him. NA-E stated he covered up R27. at that time. NA-E stated he was going to help R27 with cares when he saw the surveyor, but then stated another aide actually came in to help R27. NA-E acknowledged he did check, change or reposition R27 since the start of the morning shift today.

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When interviewed at 12:34 p.m. on 12/13/18, NA-F stated she "freshened up R27 this morning." NA-F stated she was not originally assigned to work with R27, and did not know before she helped, when R27 had been checked for wetness or when he had been last repositioned. NA-F stated she changed R27 with everybody in the room, "around 9:15 this morning." NA-F stated R27 and a number of other residents on the floor needed to be "repo'd" at least every two hours, and that is also when we would check for incontinence.

A review of R27's nursing notes and from 8/12/18 through 12/13/18, and there was no indication of current pressure ulcers fro R27. A provider progress note, dated 12/10/18, did not identify any skin breakdown or incidence of pressure ulcer.

When interviewed at 1:08 p.m. on 12/13/18, registered nurse (RN)-A stated R27 was "a total assist for all ADLs" (activities of daily living) and also R27 was incontinent of bowel and bladder. RN-A described R27's toileting program as "check and change" and stated that meant staff were to go and physically check R27's brief for wetness, and at the same time, would re-position, or at least offer to reposition R27 every time they go and check on him. RN-A stated she would "expect" R27, and any resident who needed assistance, be checked and repositioned. RN-A stated R27 was at risk to develop pressure ulcer because of his diagnoses, his refusals to be moved, and his limited mobility and continence issues. RN-A stated R27 did not have a current pressure ulcer, and said staff were still needing to reposition him as often as he will let him.

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F 686	Continued From page 54 When interviewed on 12/14/18 at 8:35 a.m. the director of nursing stated she expected a resident be groomed, and the grooming be done consistently on a daily basis. The DON stated grooming means washing the resident's head, face, under the arms, the peri-cares be done, hair brushed or combed, teeth and oral cares be done, and hands and nails be clean. The DON stated it would be expected turning and pre-positioning not only completed, but done timely. The DON stated routine care was "just something" that should be done and is an expectation, as we have staff who are trained and certified, and "that is their job." The facility policy Skin Management Guideline dated 11/28/17, identified interventions for prevention of pressure ulcer/injury must include specified turning and repositioning along with positioning. The guideline for treatment of pressure ulcers includes notifying supervisor/designee as assigned, re-evaluate turning and repositioning interventions and modify the plan of care. The guideline further indicates to update the care plan for skin integrity and nursing assistant care cards with skin concern, appropriate risk factors, and interventions as appropriate.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including	F 687		1/26/19

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F 687	Continued From page 55 to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess foot care needs for 1 of 1 residents (R56) who needed podiatry care. Findings include: R56's admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 was cognitively intact and required assistance with activities of daily living (ADL's). During observation on 12/12/18, at 12:44 p.m. R56 was laying in bed with feet bare. The bottom of R56's feet were covered in thick yellow, dry and cracked skin from R56's toes to her heels. R56 stated her feet had been that way since admission. During observation of wound rounds on 12/12/18, at 1:43 PM licensed practical nurse (LPN)-H and director or nursing (DON) cleansed, measured and applied clean dressings to R56's legs with her feet uncovered. The bottoms of both feet continued to be covered in thick, yellow dry cracked skin. Upon observation of R56's feet, LPN-H stated she was not aware R56 had build up of dead skin covering the bottoms of her feet. Staff had not informed her. Weekly skin assessments were scheduled with shower day and were documented in the computer system,	F 687	1.R56's feet have been assessed and added to Podiatry schedule per resident's preference. 2.All residents' feet will be assessed on admission and ongoing weekly with weekly skin check. Resident's assessed as needing treatment or services will be referred to their physician and/or podiatrist accordingly. 3.Staff have been educated regarding assessing foot status during weekly skin assessments, including offering podiatry services if indicated. 4.DON/designee will audit 5 residents/week for assessment of foot care needs. Audits will be brought to QAPI and reviewed	

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F 687	Continued From page 56 the condition of R56's feet should have been identified during R56's admission skin assessment and subsequent weekly skin checks. When interviewed on 12/12/18, at 1:49 p.m. DON stated she had not looked at R56's feet previously only her legs. She expected the nurses to do weekly skin assessments which were then documented in the electronic record. R56's December 2018 Treatment Administration Record (TAR) indicated weekly skin assessment were completed on Tuesday evenings. The TAR identified the nurses were to chart negative for no area of impairment and positive for area of impairment, however documentation failed to indicate a positive or negative skin assessment and lacked further information on R56's skin condition. R56's progress note dated 12/11/2018, identified R56 had a shower in the afternoon, the note did not identify R56 had thick yellow, dry and cracked skin to bilateral feet. When interviewed on 12/13/18, at 1:06 p.m. DON stated R56's foot skin was not addressed on admission or in weekly progress notes. DON stated her feet contained a build up of thick yellow dry cracked skin and needed a referral to podiatry which should have been completed on admission.	F 687		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		1/26/19

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F 688	Continued From page 57 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility failed to ensure range of motion program and/or splinting devices were consistently implemented for 3 of 5 residents (R49, R23, R25) who had identified contractures. Findings include: R49's annual Minimum Data Set (MDS) 5/17/18, indicated R49 was cognitive intact and required extensive assistance for activities of daily living (ADL) included total dependency on staff for dressing, bathing, and transfers. The MDS identified both R49's upper and lower extremities had limitations. Diagnoses included quadriplegic (paralysis of all four limbs) and epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbances). During interview on 12/12/18, 7:42 a.m. R49 stated the facility lost the splints for his hands and arms six to eight months ago (April/May 2018) and he informed registered nurse (RN)-A in	F 688	1.R49, R23, and R25 Restorative Nursing Programs have been reviewed and updated accordingly. 2.All residents with impairment in range of motion will be reviewed for potential restorative nursing or splinting programs to increase and/or prevent a decrease in range of motion or mobility. 3.Staff have been educated regarding providing appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion, including how to communicate if splints or braces are no longer able to be located. Restorative nursing program interventions will be communicated via the ROM binder, nursing assistant care sheets, and care plan and documented via Point of Care. 4.DON/designee to complete 3 random audits weekly for restorative nursing needs. Audits will be brought to QAPI for review.	

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April/May his splints were missing. RN-A did not follow-up with R49. R49 still had not received his splints.

During observation on 12/12/18, 8:30 a.m. R49 moved his coffee cup using a wooden pencil he held in his clenched contractured left hand. He moved the cup to his right closed fist, balancing the bottom of the coffee cup onto the flat surface of his right fist, between his thumb and forefinger. R49 guided the cup to his mouth using his left hand to steady the cup and he took a drink. While eating his cereal R49 used a spoon gripped in his right hand. R49 guided the his right hand and spoon with his left hand towards his bowl of cereal, R49 maneuvered the cereal onto spoon, and continued to use his left hand to support and guide the partially filled spoon to his mouth. R49's head was in the down position hovering over his bowl to shorten distant from mouth to bowl as he ate his cereal.

R49's Medication Review Report (MRR) dated 11/1/18, identified splints to bilateral upper upper extremities (elbows and hands) two times a day for four hours ordered on 8/10/18. The nursing assistants (NA) were to check with the director of nursing (DON) and remove the splints after four hours. The NA's were to document for refusal and/or his ability to tolerate the splints. No documentation was noted during record review.

R49's care plan dated 11/17/18, identified a restorative program of a splint to right elbow, right hand, left elbow and left hand initiated 8/10/18. The care plan identified activities of daily living (ADL) deficit intervention of splint assistance each morning and then removing them after four hours. Staff were to re-apply the splints during the

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evening and again remove them after four hours.

Review on 12/12/18, at 9:33 a.m. of the undated Range of Motion (ROM) book, identified R49's splint application instructions were present and directed staff with black and white photocopies of how each splint should be applied. There were no written notes addressing R49's splints.

During interview on 12/12/18, 1:14 p.m. NA-H stated she has been working at the facility for for approximately four months. NA-H worked with R49 on his range of motion and had not seen his splints. NA-H stated she had informed the nurses a "few times" the splints were missing when she first started working with R49 approximately four months ago with no results.

During interview on 12/13/18, at 11:51 a.m. the director of rehabilitation and occupational rehabilitation (OTR)-A stated she has been with facility since December 2017 and knew R49 very well. She was not aware R49's splints were missing. R49 last appointment with occupational therapy (OT) was sometime in November 2018, for a wheelchair (w/c) assessment and she did not recall a conversation of missing splints. R49 was placed on a splint program by the previous OTR which included splints for bilateral arms and hands. R49's splint information was kept in the therapy range of motion book located on his floor with photographs of both splints. OTR-A did not know if R49 wore his splints and stated R49 had refused other treatments. OTR-A stated staff were trained on how to apply the splints. OT developed a program for functional maintenance (FMP) and if R49 declined or was in need of more assistance for functional maintenance then staff would notify her. OTR-A stated if there were

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concerns with R49's OT cares the nurse coordinator would bring it up at an IDT meeting. OTR-A is only notified by staff if there are any significant changes. If any resident is sent to the hospital and returns staff inform OT. The resident is re-evaluated upon their return. OTR-A did not have knowledge of R49's recent hospital stay or of any significant changes. OTR-A stated R49 tells staff of his needs if he wants any help.

On 12/14/18, at 8:27 a.m. OTR-A stated she looked for the R49's splints, spoke with staff, and they were not able to find the splints. OTR-A stated she observed R49 feeding himself and she did not identify any functional loss of his range of motion. The previous OTR had not documented any range of motion for R49. She states she will check with R49's insurance company to re-screen resident and work with his insurance to get him new splints.

During interview on 12/14/18, at 10:30 a.m. RN-A stated she was not familiar with R49's splints and was "not quite sure" what interventions R49 had for his upper extremities. RN-A stated OTR-A screened residents every three months and attended the interdisciplinary team meetings (IDT) where she shares her recommendations with RN-A and the team. RN-A stated R49 spoke with her approximately a week ago informing her his splints were missing and requested RN-A look in his old room. RN-A does not recall if she looked. RN-A stated before last week she was not aware R49's splints were missing. RN-A was not aware of any follow-up to locate or replace R49's splints.

R23's quarterly Minimum Data Set (MDS) dated 10/11/18, identified R23 had intact cognition and

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required extensive assistance with activities of daily living (ADL). The MDS also identified R23 was impaired in the upper and lower extremities on both sides and did not ambulate or bear weight on his legs. The MDS identified a diagnosis of multiple sclerosis (a progressive disease causing muscle weakness).

R23's care plan revised 10/6/18, identified an ADL (activity of daily living) self care performance deficit related to decreased mobility and severe contractures; however, did not identify what the staff were instructed to do to prevent the worsening of contractures.

R23's undated nursing assistant care sheet identified R23's had a restorative nursing program includes; PROM (passive range of motion) daily to BUE (bilateral upper extremities) and BLE (bilateral lower extremities) daily.

During observation on 12/10/18 at 3:20 p.m., R23 was sleeping in the hallway in his wheelchair. R23's right hand was contracted (clenched into a tight fist) and was swollen with fluid.

During interview on 12/12/18 at 9:11 a.m. RN-A stated she was didn't know about any range of motion programs or contractures for R23 but would look it up. RN-A stated there was a range of motion (ROM) binder at the nurses station and all ROM programs were in the book.

On 12/13/18, at 8:29 a.m. registered nurse consultant (NC)-A reviewed R23's care plan which identified R23 had a ROM program twice a day. NC-A stated the instructions were in the ROM book at the nursing desk.

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The ROM book at the nursing station did not contain any ROM program for R23.

R23's range of motion report from the electronic record identified the following:

-November 2018, The report identified R23 was to have PROM to the lower extremities every shift. The report identified R23 received PROM to the lower extremities 24 times out of the 44 opportunities there were for completion in November. The report did not identify any PROM was provided to the upper extremities.

-December 2018, PROM report identified R23 was to have PROM to the lower extremities every shift. The report identified R23 received PROM to the lower extremities 10 times out of the 24 opportunities there were for completion in December. The report did not identify any PROM was provided to the upper extremities.

R25's annual MDS dated 7/17/18, indicated R25 required extensive assistance for activities of daily living (ADL's) including eating, dressing, and personal hygiene. R25's Diagnosis Report, dated 12/13/18, identified diagnoses including vascular dementia without behavioral disturbance, cerebral palsy, and history of traumatic brain injury.

R25's ADL functional/rehabilitation potential care area assessment (CAA) analysis of findings, dated 7/18/18, failed to identify R25's bilateral hand/finger contractures.

R25's Physician Order Summary Report dated 12/13/18, did not identify any ROM orders

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R25's care plan revised 10/18/18, identified a goal to maintain current level of function in ADL's. Interventions include skin care every morning, after all meals and snacks, and at bedtime to keep hands clean and prevent skin breakdown. R25's care plan failed to indicate interventions to treat current contractures or prevent decline in hand/finger mobility.

R25's undated nursing assistant care sheets directed staff to "see ROM (range of motion) binder."

The ROM binder at the nursing desk did not contain ROM instructions for R25.

During observations on 12/10/18, at 5:30 pm, R25 was seated in her wheelchair in the third floor dining room at a table by herself. R25 had visibly contracted bilateral hands/fingers (shortening and hardening of muscle) with the fingers turned inward, towards palm.

During observation of morning cares on 12/12/18, at 7:07 a.m., nursing assistant (NA)-A did not perform ROM on R25's hands/fingers.

When interviewed on 12/12/18, at 3:41 p.m., licensed practical nurse (LPN)-A stated NA's usually perform ROM, and she believed R25 received ROM. LPN-A looked in the "ROM" binder and confirmed there were no instructions on ROM for R25. LPN-A placed a call to the director of therapy whom confirmed there was no record of treatment for R25's contractures. DON also confirmed there was no program for R25's contractures, only eating. Director of therapy was going to look for past treatment plans.

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F 688	Continued From page 64 When interviewed on 12/14/18 at 11:44 a.m., DON stated she expected the staff to complete ROM on all contractures. DON confirmed staff have been trained to complete ROM. The undated facility policy Restorative nursing Program indicated the facility would provide interventions to promote resident's ability to adapt and adjust to living as independently as possible; the policy did not specifically address ROM or contractures.	F 688		
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	F 690		1/26/19

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F 690	Continued From page 65 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 possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to comprehensively assess the toileting needs of 1 of 5 residents (R56) reviewed for bladder incontinence. In addition, the facility failed to ensure urinary catheter interventions were implemented for 1 of 1 residents (R31) with urinary catheter and urinary track infections (UTI)'s. Findings include: INCONTINENCE R56's admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 was cognitively intact, required assistance with cares and was frequently incontinent of bladder. R56's Urinary Incontinence and Indwelling Catheter care area assessment (CAA) dated 11/26/18 indicated R56 was incontinent of bladder, there was no summary regarding urinary incontinence history, type of incontinence or toileting plan documented in the CAA. R56's admission Bladder Data Collection and Assessment dated 11/23/18, and a quarterly	F 690	1.R56□s bladder incontinence has been reassessed the care plan has been updated to reflect patient□s current state including a toileting plan to decrease incontinent episodes. R31 Urinary catheter interventions have been reviewed and updated accordingly. 2.Residents who are incontinent have been reviewed for accuracy and re-assessed if appropriate to include toileting plans. Residents with catheters have had their plan of care reviewed and interventions updated and implemented according to the plan of care. Comprehensive bladder assessments are completed ongoing upon admission, quarterly, annually or with significant changes to include a toileting plan to maintain continence unless clinical condition becomes such that continence cannot be maintained. 3.Staff education has been completed regarding resident assessment of bladder function to create individualized toileting programs upon admission, quarterly,	

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F 690	Continued From page 66 Bladder Data Collection and Assessment dated 12/1/18, identified R56 was continent of urine and was always continent. R56's care plan dated 12/2/18, identified R56 had functional bladder incontinence with interventions including encourage double voiding for overflow incontinence and to ensure unobstructed path to the bathroom. When interviewed on 12/11/18, at 8:48 a.m. R56 stated she was continent of bladder when she had admitted to the facility and was aware of when she needs to use the bathroom; however, staff did not answer her call light in time and would be incontinent of urine. During observation on 12/12/18, at 9:01 a.m. R56 was incontinent of bladder while lying in bed. R56's bedding was saturated with urine from mid back to foot of bed. NA-G assisted R56 to the edge of the bed. R56 then used her cane to ambulate to the bathroom, where R56 voided a large amount of urine. When interviewed on 12/12/18 at 9:27 a.m. nursing assistant (NA)-G stated R56 was occasionally incontinent when she was in bed but was continent when out of bed. NA-G added R56 was checked on every two hours for need and was assisted to the bathroom when requested. R56 did not have a toileting schedule. When interviewed on 12/12/18, at 12:14 p.m. licensed practical nurse (LPN)-I stated R56 was incontinent of bladder but was encouraged to get up to use the bathroom. Typically in the evening R56 would not get up to use the bathroom and had more incontinence. An assessment was not	F 690	annually, and with change in conditions. The toileting plan is communicated via the care delivery guide and care plan. Education included ensuring communicating and completing a new assessment with changes in continence status. Education was also provided regarding catheter care and proper positioning of related equipment. 4.DON/designee to complete 3 random audits weekly for bladder assessments, care plans, and ensure toileting plan is implemented accordingly. DON/designee to audit 3 patients with catheters weekly to ensure catheter interventions are implemented and met per plan of care. Audits will be brought to QAPI to be reviewed.	

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completed to assist R56 with her incontinence.

When interviewed on 12/13/18, at 12:35 p.m. LPN-H stated R56 tended to be more continent during the day then incontinent in the evening. R56's bladder assessment indicated she was continent of bladder with no further description of bladder incontinence, type of incontinence or toileting plan.

When interviewed on 12/13/18, 12:37 p.m. director of nursing (DON) stated typically a bowel and bladder assessment was completed within seven days of admission, however the assessment was not completed accurately. The DON further stated the facilities concern was to eliminate moisture as much as possible.

URINARY CATHETER
R31's quarterly Minimum Data Set (MDS) dated 10/21/8, identified R31 had intact cognition, however, required extensive assistance of staff to turn, reposition, and transfer. The MDS identified R31's diagnoses to include: urinary retention, neurogenic bladder, septicemia, and UTI in the past 30 days. Additionally, R31 was identified as having an autoimmune disease, a potentially disabling disease of the brain and spinal cord (central nervous system).

R31's care plan revised on 10/15/18 indicated R31 had a urinary catheter (A hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) and had a history of sepsis and UTI's. The care plan directed staff to ensure the drainage bag was kept below the level of the bladder. Additionally, the care plan directed staff to prevent tugging on the catheter.

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F 690	Continued From page 68 On 12/10/18, at 6:42 p.m. R31 stated she had a urinary catheter in place and had recently been hospitalized for kidney stents and had a history of urinary sepsis. During interview, R31's urinary catheter tubing was draining clear yellow urine, attached to a closed drainage system bag which was laying on the floor. The urinary drainage bag was approximately half full of clear yellow urine. On 12/14/18, at 1:20 p.m. licensed practical nurse (LPN)-A stated that the catheter bag should be kept hanging on the bed and covered for privacy. LPN-A stated if catheter bag was on the floor, R31"could get an infection" and the catheter bag could pull on the catheter insertion site. On 12/14/18, at 1:34 p.m. LPN-G stated the catheter bag should always be placed in a position lower than the bladder. Additionally, LPN-G stated having the catheter bag on the floor caused an increase potential for trauma related to pulling and an increased potential for infections. A facility policy was requested for care of urinary catheter but was not received.	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 694	1.R56 and R23 original PICC lines have	1/26/19

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F 694	Continued From page 69 review, the facility failed to ensure a peripherally inserted central catheter (PICC) line was managed per physician's orders for 1 of 1 residents (R23) observed during medication administration. Additionally, the facility failed to ensure PICC line dressings were perfmored in a manner to reduce infections for 2 of 2 residents (R23, R56) who had PICC lines. Findings include: FLUSHING PICC and DRESSING CHANGE: R23's quarterly Minimum Data Set (MDS) dated 10/11/18, indicated diagnoses which included multiple sclerosis, anemia, atrial fibrillation. The MDS indicated R23 was cognitively intact. During observation on 12/10/18, at 3:32 p.m. R23 had a PICC line in the left arm. The bottom of the dressing was not intact to his arm leaving the insertion site un-covered and visible. There was no redness or drainage observed. R23's physician's medication orders dated 12/12/18, included: -Normal Saline flush Solution 0.9% (Sodium Chloride Flush) and use 10 ml (milliliters) intravenously every 6 hours for PICC line, 10 ml before antibiotic administration per SASH protocol (saline, antibiotic, saline, heparin); and use 10 ml intravenously four times a day for PICC line, administer 10 ml after antibiotic administration, before Heparin flush, per SASH protocol. -Heparin (anti coagulant/blood thinner, used in	F 694	been discontinued. 2.All resident's with PICC lines have been reviewed and are receiving care per plan of care followed according to physician orders. 3.Licensed nursing staff educated on PICC line care and medication administration through a PICC line. New hire nursing staff will complete education on PICC line and medication administration through a PICC line prior to completing orientation process. 4.DON/designee to complete 3 audits for PICC line medication administrations, PICC line care, and dressing changes weekly. Audits will be brought to QAPI for review.	

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maintenance of a PICC line) Lock Flush Solution, 10 unit/ml; use 5 ml intravenously for times a day per SASH protocol; Flush 5 ml of heparin after antibiotic administration and after NS (normal saline) flush.

During observation of the medication pass on 12/12/18, at 1:56 p.m licensed practical nurse (LPN)-F stated R23's antibiotic was done, and the PICC line needed to be flushed. LPN-F read R23's order from the electronic medication administration record, and gathered two medications, both pre-filled syringes. One of the tube syringes was Normal Saline solution 0.9%, 10 ml (milliliters), and the other syringe, slightly smaller in size was Heparin Lock Flush solution 10 units/ml (units per milliliter) 5 ml syringe. LPN-E took both medications into R23's room and set them on a paper towel on the dresser next to R23's bed. LPN-E donned gloves, then opened an alcohol swab and cleansed the connection on the PICC line access, then connected the smaller tube to the site and pushed the medication into R23's PICC line. After removing the first syringe from the access, LPN-C opened a second alcohol swab and cleansed the PICC access, then connected the larger medication tube. As LPN-C finished pushing the medication into the access, she looked up. The surveyor asked which medication she was pushing in, and LPN-C stated she had put the Heparin in first, and she now just put in the saline. LPN-C stated "I got nervous and I mixed up the order, and should have flushed the line with the saline first." LPN-C capped the PICC access, and disposed of the used medication syringes, removed her gloves and washed her hands, and stated she needed to immediately contact the doctor.

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When interviewed on 12/12/18 at 2:04 p.m. licensed practical nurse (LPN)-F stated I put R23's heparin in first, I just realized it, I screwed up. LPN-F stated R23's order was for "SASH" which was a saline flush, then the antibiotic, then after the antibiotic finished to flush the PICC with saline, then the last step was Heparin for the lock. LPN-F stated she goofed up on the order, "its a med (medication) error."

On 12/13/18, at 12:40 p.m. LPN-D described the process for PICC line dressing changes. LPN-D stated all supplies for the dressing change came in a kit but only had one mask. The nurse wore the mask and the resident and others in the room did not. LPN-D demonstrated cleaning of the arm at the site of insertion by completing a rubbing motion from the outside of the arm in to the insertion site.

During a subsequent interview on 12/14/18 at 2:13 p.m., licensed practical nurse (LPN)-C stated the facility provided some "PICC line training yesterday," after the medication error where she mixed up the order of the flush for R23's PICC line. LPN-C stated that prior to the training she received yesterday, she did not receive special training for PICC line management from the facility. LPN-C stated that prior to taking care of R23, it had been a few years since she took care of a PICC line. LPN-C stated up to that point "I was going on my past knowledge of how to manage the line." LPN-C stated R23 did not have any adverse reaction following the medication error, when she put R23's Heparin in the line first, followed by the saline. LPN-C stated R23's doctor was notified, there were no new orders, and to just monitor

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R23 for any negative reaction. LPN-C stated R23 has since received "a number of" antibiotic doses, followed by the saline flushes and heparin locks to his PICC line. LPN-C added if there were problems, "I have not heard about any."

During interview at 11:57 a.m. on 12/14/18, infusion consultant, registered nurse (I-RN) stated when a resident gets an order for PICC, she would be part of a team that would go onsite to the nursing home and insert the ordered PICC line. The I-RN stated the team would provide minimal, basic on-site training to the floor staff and supervisor to describe the type of catheter, to review when the PICC dressing needs to be changed, and describe and review the flushing protocol. I-RN stated at that point,the nursing home would assume responsibility for the management of the PICC line and that would include flushing to maintain patency and subsequent dressing changes. The I-RN stated the flushing protocol usually was SASH (saline, antibiotic, saline then lock with heparin), and if, after the administration of the antibiotic, you put the heparin in first, that would be an incorrect administration. The I-RN stated there would be no harm to the patient, as long as the the antibiotic given was compatible with heparin. The I-RN stated with every type of catheter there is potential for complications, especially of the occlusion or clotting of the catheter, and that is why it is important to follow the orders for the flushing of the PICC line.

During interview at 4:02 p.m. on 12/14/18, registered nurse (RN)-A stated there was a medication administration error when the nurse incorrectly flushed R23's PICC line. RN-A stated the nurse should have flushed the saline first,

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then do the heparin lock. RN-A stated R23's physician was notified and there were no no orders regarding this, and we were directed to monitor R23 for any adverse reaction.

PICC DRESSING CHANGE:

R56's admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 was cognitively intact.

During interview on 12/11/18, at 8:46 a.m. R56 stated the nurse had changed her PICC line dressing; although, neither her nor the nurse wore a mask.

When interviewed on 12/12/18, at 8:48 a.m. licensed practical nurse (LPN)- I stated she was allowed to flush the PICC line, administer antibiotics and change the dressing. LPN-I had not received any competency based training from the facility but had education related to PICC lines at previous employers.

When interviewed on 12/12/18, at 3:41 p.m. LPN-H stated she had not yet had PICC line training at the facility but she did flush the PICC line and administer the antibiotic, when doing a dressing change on the PICC line she would make sure everyone was wearing a mask. LPN-H stated during the interview process potential new employees were questioned regarding previous PICC line experience and nursing staff received PICC line training yearly. The facility needed to improve PICC line training when new nursing staff were hired.

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F 694	Continued From page 74 When interviewed on 12/13/18, at 9:05 a.m. director of nursing (DON) stated the facility had previously stopped admitting complex residents; however, when residents with PICC lines were going to be admitted again training was completed with staff in March of 2018, which included competency testing. The DON stated staff hired following this time have not been provided with PICC line training. Further, she expected staff to follow the facility policies PICC lines. During observation on 12/13/18, at 12:09 p.m. R56's PICC site was clean, dry and intact with no redness, swelling or bleeding. R56 denied pain or tenderness at site During phone interview on 12/14/18, at 11:57 a.m. consultant infusion registered nurse (I-RN) talked about PICC line dressing changes. I-RN stated a PICC line dressing change was completed under sterile technique. The I-RN stated the old dressing was removed pulling toward the insertion site to avoid taking the line out. Next, the site was prepped for the new dressing by first squeezing the wipe to allow the cleaning liquid on the dressing site, and then using an up and down--not a circular motion--to scrub and create friction on the surface, and then allowing the area to air dry completely before applying a new dressing. I-RN stated there was of course "hand washing and a glove change" before applying the new dressing. I-RN stated additionally, and also very important, during the dressing change, the caregiver, patient, and anyone else present in the room "needed to wear a face mask" to minimize risk for potential infection of the PICC site, should anyone cough	F 694		

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F 694	Continued From page 75 or sneeze. During observation on 12/14/18, at 4:40 p.m. with reregistered nurse- nurse manager (RN)-A PICC dressing kit contained 2 masks. A policy regarding PICC line management was requested, but none was received.	F 694		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate with the physician to obtain orders for medications and supplements set up by the nursing staff for 1 of 1 residents (R31) who self administered medications. Findings include:	F 711	1.R31 self-administration orders have been reviewed and updated by physician. R31 has been educated regarding adding medication to self-storage and appropriate actions that need to be taken to ensure physician is aware of new medications patient desires to add to medication regimen. 2.All residents with self-medication	1/26/19

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F 711	Continued From page 76 R31's quarterly Minimum Data Set (MDS) dated 10/21/8, identified R31 had intact cognition. Diagnoses included: Vitamin D deficiency, hypomagnesemia (Low levels of magnesium in the blood stream), hypothyroidism (A condition in which your thyroid gland doesn't produce enough of certain crucial hormones), and an autoimmune disease which was potentially disabling disease of the brain and spinal cord (central nervous system). On 12/12/18 at 12:28 p.m. R31 had a large orange hinged box (approximately 10 inches in height and 18 inches in width, and 10 inches in depth) with two latches secured in place. R31 stated she kept medications at bedside, however, did not routinely use all of the medications in the box. R31 stated she routinely took a Vitamin B complex, a calcium supplement, and a Vitamin D3 capsule. R31 stated she had also taken Advil if she felt it was needed. Upon review of medications in the box with resident, the following medications were observed in the unsecured box: -Vitamin C 1000 mg (milligram-a unit of measurement) labeled as 200 caplets/bottle. The bottle was observed to approximately 1/4 full (approximately 50 caplets). -Vitamin C 500 mg labeled as 200 tablets/bottle with the bottled observed to be approximately 1/4 of a bottle (approximately 50 tablets. -Vitamin D3 1000 IU (international units-a unit of measurement) labeled as 200 caplets/bottle with the bottle observed to be approximately 200 caplets/bottle. The bottle was approximately 1/2 bottle full (approximately 100 caplets). -Vitamin D3 1000 IU softgels labeled as 200 softgels/bottle with the bottle approximately 2/3	F 711	programs have been educated regarding need to coordinate with the physician for medications and supplements consumed. Resident's self-administration programs have been reviewed and updated accordingly. 3.Staff have been educated regarding coordination with the physician for medications and supplements administered via self or facility staff. Education was also provided to licensed nursing staff for monitoring self-medication programs and ensuring medications are safely stored. 4.DON/designee to complete 3 audits of self-medication storage units weekly to ensure compliance with facility self-administration and storage of medication program. Audits will be brought to QAPI for review.	

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full (approximately 130 softgels.).
-Astragalus supplement (A herbal supplement used to treat the common cold, upper respiratory infections, fibromyalgia, and diabetes). The bottle held one fluid ounce and the bottle was observed to be greater than 3/4 full.
-Advil 200 mg (A nonsteroidal anti-inflammatory drug (NSAIDS) used to treat pain with two tablets in the bottle.
-Advil 200 mg labeled as 160 capsules/bottle with the bottle greater 3/4 full.
-Cal-Mag Citrate Complex with Vitamin D3 (1000 mg/500 mg/400 IU) supplement bottle labeled as 180 tablets/ observed to be sealed. (R31 stated she took two tablets daily).
-Vitamin E 400 IU supplement labeled 180 capsules/bottle noted to be a sealed container.
-Easy Iron 25 mg (Iron supplement) bottle labeled as 90 capsules/bottle approximately 1/2 full (45 capsules).
-L-Lysine (Dietary supplementation which has been shown to reduce chronic anxiety in humans with low dietary intake of L-lysine) 500 mg with bottle labeled as 50 tablets which was noted to have a nearly full bottle.
-Oscillococcinum (A dietary supplement which works naturally with your body to temporarily relieve flu-like symptoms, such as fatigue, headache, body aches, chills and fever doses 0.04 ounces each
-Cranberry concentrate capsules (A supplement which can interfere with unwanted bacteria in the urinary tract)500 mg per capsule with three capsule in the bottle.
-Cranberry plus Vitamin C 4200 mg per softgels (Cranberry 168 mg /Vitamin C 40 mg/Vitamin E 6 IU) (A product reported to support the integrity of bladder walls to promote urinary health in both men and women in addition to supporting

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immune function) full bottle/labeled 120 softgels.
-Zinc 50 mg (A supplement which is indicated to help the immune system fight off invading bacteria and viruses). The bottle was noted to have approximately 15 tablets.
-B-Complex with Folic Acid plus Vitamin C bottle labeled to have 125 caplets/bottle with the bottle approximately 1/4 bottle full.
-Hi Potency B Stress supplement with approximately 15 tablets in the bottle.
-Immodium (A product used to treat diarrhea) bottle labeled to have 30 caplets/bottle with the bottle approximately 3/4 full bottle present.

Additionally, there was a plastic bag with 14 vial like containers which R31 described as "homeopathy" products which were made in France which were used for miscellaneous purposes.

R31's Medication Review Report dated 12/3/18, identified orders for Cranberry Concentrate 500 mg daily for urinary tract infections (UTI's), Culturelle Digestive Health 108-200 mg one capsule twice daily as a probiotic (Live bacteria and yeasts, which are helpful, especially for the digestive system), Niacinamide 500 mg one capsules by mouth for auto immune disease, and Vitamin B Complex one capsule by mouth daily for a supplement.

The physicians also lacked orders for the following: Vitamin C 1000 mg, -Vitamin C 500 mg , -Vitamin D3 1000 IU, -Astragalus supplement, Advil 200 mg, Cal-Mag Citrate Complex with Vitamin D3, Vitamin E 400 IU, Easy Iron 25 mg, L-Lysine, Oscillococcinum, Cranberry concentrate capsules, Cranberry plus Vitamin C 4200 mg (Cranberry 168 mg /Vitamin C 40 mg/Vitamin E 6

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F 711	Continued From page 79 IU), Zinc 50 mg, B-Complex with Folic Acid plus Vitamin C, Hi Potency B Stress supplement, and Immodium. The physician's orders also lacked indication for use of homeopathic properties. On 12/14/18, at 1:20 licensed practical nurse (LPN)-A stated she administered medications as ordered by the physician to R31. LPN-A stated R31 also had kept medications/supplements in her room. , LPN-A stated she had set up meds for R31 as R31 directed. LPN-A used the supplements stored in R31's room to set up her medication box . LPN-A reviewed R31's physician orders, which included orders for cranberry concentrate, Vitamin Complex capsule, and whey protein powder. LPN-A stated the physician orders did not list all medications kept by R31 in her room. LPN-A stated R31 kept her medications and supplements in a tackle box in her room, at her bedside on the table. LPN-A stated she did not go into R31's med box "I don't go in it because I respect her privacy." On 12/14/18, at 1:34 p.m. LPN-G was aware R31 had meds at bedside. Additionally, LPN-G stated all medications and supplements kept at bedside required a physician authorization, adding, this was important to prevent drug interactions. LPN-G stated when the self administration of medication assessment was completed it was for R31 medications and supplements ordered by the physician and did not assess other products. .	F 711		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		1/26/19

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F 725	Continued From page 80 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet the assessed needs for 4 of 6 residents (R27, R15, R25, R23) reviewed for activities of daily living (ADLs) and 1 of 3 residents (R27) reviewed for pressure ulcer care. In addition, for 10 of 10 residents (R16, R49, R4, R50, R56, R2, R7, R10, R39, R57) and 5 of 5 staff members (NA-M, LPN-K, SC-A, NA-I, NA-A)	F 725	1. R27, R15, R25, R23 care needs are being completed per plan of care. R16, R49, R4, R50, R56, R2, R10, R39, and R57 cares are being fulfilled per plan of care. Residents have been educated on¿staffing levels and staff deployment has been reviewed and adjustments made where appropriate. 2. All residents are receiving care per	

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F 725	Continued From page 81 who expressed concerns with a lack of sufficient nursing staff in the facility. The lack of sufficient nursing staff to meet assessed needs had potential to affect all 66 residents who resided within the facility. Findings include: ASSESSED NEEDS NOT BEING MET: ADLS: R27's care plan dated 10/19/18, identified R27 had an alteration in urinary continence related to dementia, a history of significant stroke, and being bed bound with total dependence on staff for all cares. Further, the care plan directed staff to check and change R27 every two hours and PRN (as needed.) R27 was continuously observed on 12/13/18, from 5:44 a.m. to 9:11 a.m. to be lying in his bed without being checked for incontinence (3 hours and 27 minutes). At 9:20 a.m., NA-F entered the room along with registered nurse (RN)-A and began morning cares for R27. When interviewed on 12/13/18 at 9:45 a.m., nursing assistant (NA)-E acknowledged R27 had not been checked and changed according to his care plan since the start of the morning shift on 12/13/18. NA-F expressed R27, along with several other residents, needed to be checked and assisted with incontinence care every two hours. During interview on 12/13/18, at 1:08 p.m. registered nurse (RN)-A stated R27 was "a total assist for all ADLs (activities of daily living)," and incontinent of bowel and bladder. RN-A	F 725	care plan with current deployment of staff. Deployment of staff will be determined by reviewing resident number, acuity levels by unit and assignments, and dx of the resident population according to the Facility Assessment. 3. Nursing staff and staffing scheduler have been re-educated regarding staffing levels and deployment of staff to include acuity and resident needs. 4. DON/Designee will audit each unit weekly to ensure there is sufficient staffing to meet residents care planned needs.¿ Audit will include resident and staff interviews, and ADL/wound care observations. Audit results to be reviewed in QAPI.	

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explained she would "expect" R27, and any resident who needed assistance, be checked timely.

R15 was observed on 12/12/18, at 6:55 a.m. as NA-E completed morning cares which included washing up, perineal cares, and dressing. R15 was assisted into a wheelchair by NA-E and NA-B. NA-E proceeded to brush R15's hair and then wheeled her down to the dining room. No oral care(s) were provided or offered to R15.

When interviewed at 1:24 p.m. on 12/12/18, NA-E stated R15 was unable to complete personal cares, including oral cares, and was dependent on staff for them. NA-E stated he did not complete R15's oral cares this morning and stated she should have had her teeth brushed or used a toothette, adding, "I guess they got missed."

When interviewed on 12/13/18 at 1:15 p.m. registered nurse (RN)-A stated she would expect ADLs, including oral cares, be offered and completed. RN-A explained if oral cares were offered but refused, she would expect staff to try again later, and "I would expect it be completed."

R25 was observed on 12/10/18, at 5:41 p.m., to have visibly long finger nails with visible black debris under them. On 12/11/18, at 11:01 a.m. and 4:01 p.m., subsequent observations were made of R25 and she continued to have long finger nails with visible black debris under them. During observation of morning cares on 12/12/18, at 7:07 a.m., nursing assistant (NA)-A did not perform hand hygiene on R25's hands/fingers.

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Further observation on 12/13/18 at 11:42 a.m., showed R25 to still have long finger nails with visible black debris under them.

On 12/13/18 at 12:21 p.m., licensed practical nurse (LPN)-J stated R25 often refuses nail care, which would be documented in the treatment record that cares were attempted but refused. LPN-J reviewed R25's treatment record and found no record to provide nail care or indication of refusals. LPN-J then observed and verified R25's visibly long nails with black substance present underneath them.

R25's behavior symptoms point of care (POC) documentation for the past 30 days (11/13/18 through 12/13/18), indicated no rejection of care by R25.

On 12/14/18, at 11:44 a.m. the director of nursing (DON) stated her expectations were for nail care to be provided weekly, on bath days, and as needed.

R23's quarterly MDS dated 10/11/18, identified R23 had intact cognition and required extensive to total assistance from staff with activities of daily living (ADL) and bathing. On 12/13/18, at 7:52 a.m. R23's hair was visibly greasy and unkempt. R23 had a foul, sweaty odor and stated he was going to get a hair cut that day. R23 stated the facility staff had not washed his hair for several months and he would have the barber cut his hair once per month just to make sure he got his hair washed. R23 had never received a shower or bath in the facility, but was instead given bed baths and his hair was not washed during the bed baths.

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F 725	Continued From page 84 On 12/13/18, at 11:23 a.m. R23 continued to have visibly greasy hair and had a foul odor. R23 had approximately 1/4 inch facial hair and his nails were long with a dark substance underneath the nails. R23 stated staff did not complete any personal cares that morning with the exception of providing him with a clean gown. On 12/13/18, at 2:53 p.m. R23 was lying in bed. R23 remained in the hospital-type gown, with long facial hair present, greasy hair, and body odor. A resident and family Christmas party was scheduled to start at 4:00 p.m.. R23 indicated he would "really like to go" but only if staff would perform his basic cares. R23 stated it was the third day he remained in bed due to not having cares completed by staff. On 12/14/18, at 11:23 a.m. R23 was dressed , however R23's fingernails continued to have a dark substance and debris underneath them. R23 could not remember the last time he had a bath or shower. R23's face remained unshaven, his hair was greasy and uncombed. R23 stated no one had offered to brush his teeth that day. "They [staff] usually don't". Being clean and kempt was very important to him. "I used to shower and brush my teeth once a day but it is a rare thing now". A strong body odor remained. Documentation Survey Report (CNA documentation of cares) dated 10/1/18 to 12/12/18, identified R23 was to be bathed every morning and evening shift. However, the report identified a shower had only been completed once, and a bed bath twice in October; two bed baths were documented in November; and two bed baths documented in December.	F 725		

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During interview on 12/12/18, at 9:11 a.m. NA-B stated R23 only received bed baths and the staff did not wash R23's hair.

During interview on 12/14/18 at 12:10 p.m. RN-A stated her expectation was morning and evening cares were to include residents being washed up, have their teeth brushed, hair combed and dressed in personal clothing. R23 was to receive at minimum of one shower every week. SEE F677 FOR ADDITIONAL INFORMATION.

LACK OF TIMELY REPOSITIONING:
R27 was continuously observed on 12/13/18, from 5:44 a.m. to 9:11 a.m. to be lying in his bed without being checked for incontinence (3 hours and 27 minutes). R27 was continuously observed on 12/13/18, from 5:44 a.m. to 9:11 a.m. to be lying in his bed without being repositioned (3 hours and 27 minutes). At 9:20 a.m., NA-F entered the room along with registered nurse (RN)-A and began morning cares for R27.

When interviewed on 12/13/18 at 9:45 a.m., nursing assistant (NA)-E stated he had gone into R27's room "to check on" him shortly after the start of the shift, but did not reposition or check him. NA-E acknowledged he did not reposition R27 since the start of the morning shift on 12/13/18. During interview at 12:34 p.m., NA-F stated R27 needed to be "repo'd" at least every two hours.

On 12/13/18, at 1:08 p.m. registered nurse (RN) -A stated she would "expect" R27, and any resident who needed assistance, be checked and repositioned timely. SEE F686 FOR

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F 725	Continued From page 86 ADDITIONAL INFORMATION. RESIDENT / FAMILY CONCERNS: R16's quarterly Minimum Data Set (MDS) dated 9/28/18, identified R16 had intact cognition and required extensive assistance with ADLs. When interviewed on 12/10/18, at 2:36 p.m. R16 stated it "takes forever" to get served his meals adding it was "tough to get help here." R16 explained the past weekend he had to use his call light to get help to get up from bed after 10:30 a.m. as nobody had been in to help him yet. The call light then remained on for over 45 minutes so he had to holler out into the hallway for help. R16 explained is was not uncommon to wait for over 30 minutes to get assistance after turning the call light on adding the facility was often running short staffed. R49's quarterly MDS dated 11/17/18, identified R49 had intact cognition and was totally dependent on staff for his ADLs. During interview on 12/10/18, at 3:09 p.m. R49 stated he had asked for a shower two times a week but often only received one shower adding staff had canceled the second shower as they did not have time to do it. R49 explained the staff often voiced they were short staffed and always rushed causing his range of motion program to not be completed on weekends, a long call light response time, and a lack of timely repositioning during the overnight which sometimes went four or five hours between repositions. Further, R49 stated he had spoken with registered nurse (RN) -A, the director of nursing (DON) and administrator about these concerns, however, the concerns persisted.	F 725		

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R4's quarterly MDS dated 9/11/18, identified R4 had intact cognition and required extensive assistance with his ADLs. During interview on 12/10/18, at 3:12 p.m. R4 explained there was not enough staff in the facility to provide care as, at times, when he puts his call light on it takes a long time, sometimes up to an hour, for someone to answer it. Further, on 12/11/18, at 3:53 p.m. R4 again expressed frustration with the lack of staff in the facility and explained he had been up in his wheelchair all morning, and didn't get laid down until around 1:30 p.m. because the staff were too busy helping others and were not able to help him.

R50's quarterly MDS dated 11/16/18, identified R50 had moderate cognitive impairment and required extensive assistance with ADLs. On 12/10/18, at 3:56 p.m. R50 was interviewed and explained there was not enough staff in the facility. R50 stated he used a urostomy (a surgical procedure that creates a stoma for the urinary system) and often the bag was not addressed or emptied as there was not enough nurses. R50 showed the surveyor his urostomy bag which was completely full of urine causing it to leak. Further, R50's room had a strong odor of urine present.

R56's admission MDS dated 11/23/18, identified R56 had intact cognition and required extensive assistance with bed mobility, transfers, and dressing. During interview on 12/11/18, at 8:24 a.m. R56 stated there was not enough staff in the facility. R56 sometimes had to wait 15 to 20 minutes after turning on her call light for assistance to the bathroom; this caused her to be incontinent of bladder which occurred two to three times a week.

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R2's quarterly MDS dated 9/7/18, identified R2 had intact cognition and required extensive assistance for his ADLs. When interviewed on 12/11/18, at 8:25 a.m. R2 expressed there was not enough staff to meet the resident' needs in the facility. There had been recent cutbacks and changes in the staffing which caused the cares to suffer. R2 stated even simple grooming, like having your hair washed, was something you had to repeatedly ask for now.

R7's annual MDS dated 9/16/18, identified R7 had short and long term memory impairment, however, was independent with daily decision making, and required extensive assistance with his ADLs. When interviewed on 12/11/18, at 9:21 a.m. R7 expressed there was not enough staff working in the facility to help meet resident' needs adding he thought there were 18 residents assigned to one aide and it was not enough help. R7 stated his call light took an hour to be answered, at times, except when State surveyors are here, then the response is much quicker. R7 explained his wife visited often and would leave in the evening with his call light being on; then call him back later and the call light was still on. R7 stated he had suffered bowel incontinence as a result of the time it took to get his call light answered and the poor staffing.

On 12/12/18, at 10:59 a.m., a resident council meeting was held with R10, R39, R49, R50, and R57 in attendance. R10's quarterly MDS, dated 9/19/18, identified R10 had intact cognition. R39's quarterly MDS, dated 10/31/18, identified R39 had intact cognition. R49's quarterly MDS, dated 11/17/18, identified R49 intact cognition. R50's quarterly MDS, dated 11/16/18, identified

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R50 had intact cognition. R57's quarterly MDS, dated 11/22/18, identified R57 had intact cognition.

A concern was expressed by the group regarding a long "call light wait time" and range of motion (ROM) programs not being completed. R39 explained she sometimes has to lay in bed for 30 minutes before they answer her call light. R49 stated he had waited longer even before, and has went to the bathroom in his pants because of waiting. R49 added the staff always tell him they will do his ROM later, however, it never gets done, nor was he consistently repositioned timely. Nearly all of the council meeting attendees acknowledged a long call light response time which occurred on all shifts.

STAFF CONCERNS WITH STAFFING:
When interviewed on 12/13/18, at 5:44 a.m. nursing assistant (NA)-M stated the third and fourth floor(s) do not have enough staff to meet residents needs timely, like answering call lights and helping residents to the bathroom. The resident level of care was high and there were several residents who required two person assistance, and/or who demonstrated increased behaviors which required more staff to address.

When interviewed on 12/13/18, at 5:51 a.m. licensed practical nurse (LPN)-K stated the concern regarding not enough staff to care for the residents needs was brought up to administration at every monthly staff meeting, and were told by administration informed them the number of staff scheduled depended on the number of residents, and not the acuity of the resident population.

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During interview on 12/14/18, 3:10 p.m. staffing coordinator (SC)-A stated the facility was currently short staffed on all shifts. They fill most shifts with their staff working additional hours, and do use agency staff to cover shifts, at times, or have the nurse managers work the un-filled shifts.

During interview on 12/14/18, 3:30 p.m. NA-L stated she had asked for more hours during the last two months and additionally she was also asked two or more times a week to work more hours. NA-L stated there is not enough staff or time in the evenings to get assigned tasks and cares completed.

During interview on 12/14/18, 03:51 p.m. NA-A stated she was often asked to stay late and work additional hours. She was currently working a 16 hour day, and, even though her day off was the next day, she was scheduled to work 16 hours. SC-A had asked her if she would also work a 16 hour shift on the upcoming Saturday and Monday. NA-A stated she was asked to work extra hours almost every day she was at work as the facility was always short staffed. NA-A expressed she was supposed to be scheduled 60 hours a pay period, however, due to the lack of sufficient staffing, she had been working over 100 hours a pay period for the past few months.

A series of untitled flow sheets were provided to demonstrate the daily schedule for 12/10/18 to 12/14/18. These flow sheets listed each shift (6 a.m. to 2:30 p.m., 2:00 p.m. to 10:30 p.m., and, 10:00 p.m. to 6:00 a.m.) with subsequent staff names' assigned to work the shift. These flow sheets identified the following empty spaces and corresponding, unfilled shifts:

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F 725	Continued From page 91 12/10/18 - One AM NA absent on fourth floor. 12/11/18 - One AM nurse on the second floor; two AM nurses on third floor; one AM NA on third floor; one PM nurse on second floor, and, one PM nurse on fourth floor. 12/12/18 - One AM NA on fourth floor; one PM nurse on second floor, and, one PM NA on fourth floor. 12/13/18 - One night (NOC) nurse on second floor. 12/14/18 - One AM NA on second floor; one AM NA on fourth floor; two PM NA on fourth floor; one NOC nurse on fourth floor, and, one NOC NA on second floor. The provided schedules lacked any evidence or dictations to demonstrate these open shifts had been filled or demonstrating staff stayed over to ensure resident care needs were met. A facility policy on nursing staffing was not provided.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		1/26/19

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F 726	Continued From page 92 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and doucment review the facility failed to ensure licensed staff were provided training with demonstration of competenacy to ensure safe delivery of medications intravenously (IV-giving medicines or fluids through a needle or tube inserted into a vein) and provide maintainence of the intravenous site with use of IV saline flush and heparinaizaiton for 2 of 2 residents (R23, R59) currently receiving IV medications. Findings include: The CMS-672 (form completed by the provider summarizing resident needs and services)	F 726	1.R56 and R23 have had original PICC lines removed. 2.All Resident's with IV therapy are receiving those service from competent nursing staff 3.Education has been completed with Licensed Nursing staff related to IV therapy, medication administration and IV cares. 4.DON/designee to complete 3 random audits regarding medication administrations, picc line care, and dressing changes weekly. Audit results to be reviewed in QAPI.	

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identified two residents were receiving intravenous therapy.

R23's quarterly Minimum Data Set (MDS) dated 10/11/18, indicated diagnoses which included multiple sclerosis, anemia, atrial fibrillation. The MDS indicated R23 was cognitively intact.

During observation on 12/10/18, at 3:32 p.m. R23 had a PICC line in the left arm. The bottom of the dressing was not intact to his arm leaving the insertion site un-covered and visible. There was no redness or drainage observed.

During medication administration observation on 12/10/18, at 6:03 p.m. licensed practical nurse (LPN)-B stated R23's dressing was not intact and the dressing had not been changed since his return from the hospital, on 11/28/18. LPN-B requested RN-A be in the room as she was doing the IV medication administration. LPN-B gloved and stated her process would be to give the heparin (anticoagulant), saline flush, antibiotic and saline flush. RN-A questioned if the right order of administration was being used and LPN-B stated, yes and repeated heparin, saline, antibiotic, and saline. RN-A agreed with LPN-B at the time. LPN-B proceeded to remove the cap off the heparin and RN-A told LPN-B to stop and was going to double check the physician order. RN-A returned after approximately five minutes and stated the correct series of administration was saline, antibiotic, saline, and heparin also known by the SASH acronym.

R23's physician's medication orders dated 12/12/18, included:

-Normal Saline flush Solution 0.9% (Sodium

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Chloride Flush) and use 10 ml (milliliters) intravenously every 6 hours for PICC line, 10 ml before antibiotic administration per SASH protocol (saline, antibiotic, saline, heparin); and use 10 ml intravenously four times a day for PICC line, administer 10 ml after antibiotic administration, before Heparin flush, per SASH protocol.

-Heparin (anti coagulant/blood thinner, used in maintenance of a PICC line) Lock Flush Solution, 10 unit/ml; use 5 ml intravenously for times a day per SASH protocol; Flush 5 ml of heparin after antibiotic administration and after NS (normal saline) flush.

During observation of the medication pass on 12/12/18, at 1:56 p.m licensed practical nurse (LPN)-F stated R23's antibiotic was completed, and the PICC line needed to be flushed. LPN-F read R23's order from the electronic medication administration record, and gathered two medications, both pre-filled syringes. One of the tube syringes was Normal Saline solution 0.9%, 10 ml (milliliters), and the other syringe, slightly smaller in size was Heparin Lock Flush solution 10 units/ml (units per milliliter) 5 ml syringe. LPN-E took both medications into R23's room and set them on a paper towel on the dresser next to R23's bed. LPN-E donned gloves, then opened an alcohol swab and cleansed the connection on the PICC line access, then connected the smaller tube to the site and pushed the medication into R23's PICC line. After removing the first syringe from the access, LPN-C opened a second alcohol swab and cleansed the PICC access, then connected the larger medication tube. As LPN-C finished pushing the medication into the access, she

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looked up. The surveyor asked which medication she was pushing in, and LPN-C stated she had put the Heparin in first, and she now just put in the saline. LPN-C stated "I got nervous and I mixed up the order, and should have flushed the line with the saline first." LPN-C capped the PICC access, and disposed of the used medication syringes, removed her gloves and washed her hands, and stated she needed to immediately contact the physician.

When interviewed on 12/12/18 at 2:04 p.m. licensed practical nurse (LPN)-F stated I put R23's heparin in first, I just realized it, I screwed up. LPN-F stated R23's order was for "SASH" which was a saline flush, then the antibiotic, then after the antibiotic finished to flush the PICC with saline, then the last step was Heparin for the lock. LPN-F stated she goofed up on the order, "its a med (medication) error."

On 12/12/18, at 3:35 p.m. LPN-J stated she had worked at the facility for four months and had not received any training on IV's from the facility. LPN-J stated the only training on IV's was what was received in LPN training course.

During a subsequent interview on 12/14/18, at 2:13 p.m. LPN-C stated the facility provided some "PICC line training yesterday," (12/13/18) after the medication error where she mixed up the order of the flush for R23's PICC line. LPN-C stated that prior to the training she received yesterday, she did not receive any special training for PICC line management from the facility. LPN-C stated that prior to taking care of R23, it had been a few years since she took care of a PICC line. LPN-C stated up to that point "I was going on my past knowledge of how to manage the line." LPN-C

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stated R23 did not have any adverse reaction following the medication error, when she put R23's Heparin in the line first, followed by the saline. LPN-C stated R23's physician was notified, there were no new orders, and to just monitor R23 for any negative reaction. LPN-C stated R23 has since received "a number of" antibiotic doses, followed by the saline flushes and heparin locks to his PICC line. LPN-C added if there were problems, "I have not heard about any."

During interview at 11:57 a.m. on 12/14/18, infusion consultant, registered nurse (I-RN) stated when a resident gets an order for PICC, she would be part of a team that would go onsite to the nursing home and insert the ordered PICC line. The I-RN stated the team would provide minimal, basic on-site training to the floor staff and supervisor to describe the type of catheter, to review when the PICC dressing needs to be changed, and describe and review the flushing protocol. I-RN stated at that point,the nursing home would assume responsibility for the management of the PICC line and that would include flushing to maintain patency and subsequent dressing changes. The I-RN stated the flushing protocol usually was SASH (saline, antibiotic, saline then lock with heparin), and if, after the administration of the antibiotic, you put the heparin in first, that would be an incorrect administration. The I-RN stated there would be no harm to the patient, as long as the the antibiotic given was compatible with heparin. The I-RN stated with every type of catheter there is potential for complications, especially of the occlusion or clotting of the catheter, and that is why it is important to follow the orders for the flushing of the PICC line.

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During interview at 4:02 p.m. on 12/14/18, registered nurse (RN)-A stated there was a medication administration error when the nurse incorrectly flushed R23's PICC line. RN-A stated the nurse should have flushed the saline first, then do the heparin lock. RN-A stated R23's physician was notified and there were no no orders regarding this, and we were directed to monitor R23 for any adverse reaction.

R56's admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 was cognitively intact.

During interview on 12/11/18, at 8:46 a.m. R56 stated the nurse had changed her PICC line dressing although neither her nor the nurse wore a mask.

When interviewed on 12/12/18, at 8:48 a.m. licensed practical nurse (LPN)- I stated she was allowed to flush the IV, administer antibiotics and change the dressing. LPN-I had not received any competency based training from the facility about PICC lines but had education related from previous employers.

When interviewed on 12/12/18, at 3:41 p.m. LPN-H stated she had not yet had PICC line training at the facility but she did flush the IV and administer the antibiotic, when doing a dressing change on the PICC line she would make sure everyone was wearing a mask. LPN-H stated during the interview process potential new employees were questioned regarding previous PICC line experience and nursing staff received PICC line training yearly. The facility needed to improve PICC line training when new nursing staff were hired.

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F 726	Continued From page 98 When interviewed on 12/13/18, at 9:05 a.m. director of nursing (DON) stated the facility had previously stopped admitting complex residents; however, when residents with PICC lines were going to be admitted again training was completed with staff in March of 2018, which included competency testing. The DON stated staff hired following this time have not been provided with any PICC line training. During observation on 12/13/18, at 12:09 p.m. R56's PICC site was clean, dry and intact with no redness, swelling or bleeding. R56 denied pain or tenderness at site During interview on 12/13/18, at 4:04 p.m. RN-B stated he had changed R56's dressing to the PICC line on 12/10/18. RN-B stated sterile technique was used and only the nurse wore a mask. The patient was not given a mask to wear during the dressing change because there was only one mask in the dressing kit. During observation on 12/14/18, at 4:40 p.m. with registered nurse- nurse manager (RN)-A PICC dressing kit contained 2 masks. Training records and documentation provided by the DON identified 11 of the current 27 licensed nursing staff had received previous training from the facility. The facility provided PICC Line Training sign in sheet indicated an objective to demonstrate proper technique of flushing, blood draw and dressing change was part of the training, and competency testing was only available for 3 of the 11 nurses who received training.	F 726		

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F 726	Continued From page 99 The Facility Assessment revised on 10/18, identified infusion therapy was a service available to residents residing within the facility, however, was not included as a current service provided to residents. The assessment indicated under the category of medications; The facility needed to be aware of its limitations with medication administration. Additionally, it identified medication provision would be completed through a variety of routes, which included oral, nasal, buccal, subcutaneiously, injection, and IV therapy. The assessment indicated under the section headed "Staff training/eduaation and competencies" indicated medication training should be completed for injectable, oral, subcutaeous, or topical medication. The training did not identify IV therapy, however, the listing identified it was not inclusive of all training provided. The assessment indicated new employees were in-serviced and were to complete mandatory competancies prior to rendering patient care. The policy indicated return demonstrations are required prior to completing any competancy as well as a passing score on the required post-test.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		1/26/19

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F 755	Continued From page 100 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper medication storage was implemented for 1 of 1 residents (R31) who had been assessed as competent to self administer medications. Findings include: R31's quarterly Minimum Data Set (MDS) dated 10/21/8, identified R31 had intact cognition. The MDS identified R31's diagnoses to include: Vitamin D deficiency, hypomagnesemia (Low levels of magnesium in the blood stream),	F 755	1. R31 has been educated regarding self-administration of medication policy, including storage and appropriate actions that need to be taken to ensure physician is aware of new medications patient desires to add to medication regimen. 2.All residents with self-administration programs have been reviewed and updated accordingly. 3.Staff have been educated regarding proper medications storage, including for residents who have been assessed as competent to self-administer medications.	

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F 755	Continued From page 101 hypothyroidism (A condition in which your thyroid gland doesn't produce enough of certain crucial hormones), and an autoimmune disease which was potentially disabling disease of the brain and spinal cord (central nervous system). R31's care plan, revised on 10/21/18, indicated R31 was assessed as able self administer medications after they had been initially set up by nurse, however, it did not specify how medications were to be stored in R31's room to assure safety for both residents and potential risks to others. R31's Self Administration Data Collection and Assessment dated 10/21/18, indicated R31 was able able to demonstrate safe storage of medication in her room. On 12/12/18, at 12:28 p.m. R31 had a large orange hinged box (approximately 10 inches in height and 18 inches in width, and 10 inches in depth) with two latches secured in place which lacked a locking device or mechanism. R31 stated she kept medications at bedside, however, stated she did not routinely use all of the medications in the box. R31 stated she routinely took a Vitamin B complex, a calcium supplement, and a Vitamin D3 capsule. R31 stated she had also taken Advil if she felt it was needed. Upon review of medications in the box with resident, the following medications were observed in the unsecured box: -Vitamin C 1000 mg (milligram-a unit of measurement) labeled as 200 caplets/bottle. The bottle was observed to approximately 1/4 full (approximately 50 caplets). -Vitamin C 500 mg labeled as 200 tablets/bottle	F 755	4.DON/designee to complete 3 audits of self-medication storage units weekly. Audits will be brought to QAPI for review.	

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F 755	Continued From page 102	F 755		

with the bottled observed to be approximately 1/4 of a bottle (approximately 50 tablets.
-Vitamin D3 1000 IU (international units-a unit of measurement) labeled as 200 caplets/bottle with the bottle observed to be approximately 200 caplets/bottle. The bottle was approximately 1/2 bottle full (approximately 100 caplets).
-Vitamin D3 1000 IU softgels labeled as 200 softgels/bottle with the bottle approximately 2/3 full (approximately 130 softgels.).
-Astragalus supplement (A herbal supplement used to treat the common cold, upper respiratory infections, fibromyalgia, and diabetes). The bottle held one fluid ounce and the bottle was observed to be greater than 3/4 full.
-Advil 200 mg (A nonsteroidal anti-inflammatory drug (NSAIDS) used to treat pain with two tablets in the bottle.
-Advil 200 mg labeled as 160 capsules/bottle with the bottle greater 3/4 full.
-Cal-Mag Citrate Complex with Vitamin D3 (1000 mg/500 mg/400 IU) supplement bottle labeled as 180 tablets/ observed to be sealed. (R31 stated she took two tablets daily).
-Vitamin E 400 IU supplement labeled 180 capsules/bottle noted to be a sealed container.
-Easy Iron 25 mg (Iron supplement) bottle labeled as 90 capsules/bottle approximately 1/2 full (45 capsules).
-L-Lysine (Dietary supplementation which has been shown to reduce chronic anxiety in humans with low dietary intake of L-lysine) 500 mg with bottle labeled as 50 tablets which was noted to have a nearly full bottle.
-Oscillococcinum (A dietary supplement which works naturally with your body to temporarily relieve flu-like symptoms, such as fatigue, headache, body aches, chills and fever doses 0.04 ounces each

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F 755	Continued From page 103 -Cranberry concentrate capsules (A supplement which can interfere with unwanted bacteria in the urinary tract)500 mg per capsule with three capsule in the bottle. -Cranberry plus Vitamin C 4200 mg per softgels (Cranberry 168 mg /Vitamin C 40 mg/Vitamin E 6 IU) (A product reported to support the integrity of bladder walls to promote urinary health in both men and women in addition to supporting immune function) full bottle/labeled 120 softgels. -Zinc 50 mg (A supplement which is indicated to help the immune system fight off invading bacteria and viruses). The bottle was noted to have approximately 15 tablets. -B-Complex with Folic Acid plus Vitamin C bottle labeled to have 125 caplets/bottle with the bottle approximately 1/4 bottle full. -Hi Potency B Stress supplement with approximately 15 tablets in the bottle. -Immodium (A product used to treat diarrhea) bottle labeled to have 30 caplets/bottle with the bottle approximately 3/4 full bottle present. Additionally, there was a plastic bag with 14 vial like containers which R31 described as "homeopathy" products which were made in France which were used for miscellaneous purposes. On 12/14/18, at 1:20 p.m. licensed practical nurse (LPN)-A stated R31 kept medications/supplements in her room and LPN-A had set up medications/supplements as directed by R31. LPN-A stated R31 kept her medications/supplements in a tackle box at her bedside on the table and stated the box should have been locked, however, added "I don't go in it because I respect her privacy." LPN-A stated the medication box should be kept locked to prevent	F 755		

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F 755	Continued From page 104 confused residents from going into the room and taking medications not prescribed for them. On 12/14/18, at 1:34 p.m. LPN-G stated residents with medications at bedside had to be assessed to determine if they are able to safely administer the medications and store them appropriately in secured area. LPN-G was aware R31 had meds at bedside, but was unaware it was not locked. LPN-G stated she did not feel R31 could physically move box independently related to physical limitations. A facility policy revised 11/28/16, indicated the resident was to store the medication storage compartment in the resident room where other residents could not access the medications and the storage compartment was to be kept locked at all times when not in use.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician's orders without error for 2 of 6 residents (R23, R8) observed to receive medication during the survey. This resulted in a facility medication error rate of 6.25% (percent). Findings include:	F 759	1.R23 Physician was updated of medication error and no changes were made at that time. R8 MD was updated and the order adjusted to reflect correct time of administration. Investigation and appropriate actions taken at time of incident, including updating patient/guardian and physician. 2.All residents' medications are being	1/26/19

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F 759	Continued From page 105 R23's quarterly Minimum Data Set (MDS) dated 10/11/18, identified diagnoses which included multiple sclerosis, anemia, atrial fibrillation. The MDS indicated R23 was cognitively intact. R23's physician's medication orders dated 12/12/18, included: -Normal Saline flush Solution 0.9% (Sodium Chloride Flush) and use 10 ml (milliliters) intravenously every 6 hours for PICC line, 10 ml before antibiotic administration per SASH protocol (saline, antibiotic, saline, heparin); and use 10 ml intravenously four times a day for PICC line, administer 10 ml after antibiotic administration, before Heparin flush, per SASH (Saline, Antibiotic, Saline Heparin) protocol. -Heparin (anti coagulant/blood thinner, used in maintenance of a PICC line) Lock Flush Solution, 10 unit/ml; use 5 ml intravenously for times a day per SASH protocol ; Flush 5 ml of heparin after antibiotic administration and after NS (normal saline) flush. During observation of the medication pass at 1:56 p.m. on 12/12/18, licensed practical nurse stated R23's antibiotic was done, and the PICC line needed to be flushed. LPN-C read R23's order from the electronic medication administration record, and said aloud it was a 'SASH' order. LPN-C then gathered two medications, normal saline and heparin, both pre-filled syringes. The syringe of Normal Saline solution was about 4" (inches) in length, and about 1/2" wide; the heparin syringe was about one inch shorter in length. LPN-C took both medications into R23's room and set them on a paper towel on the	F 759	administered per order including time specific medications. 3.Education provided to all licensed nursing staff regarding mediation administration including ensuring proper transcription with 3 checks to prevent medication errors from occurring. 4.DON/designee to complete 3 medication administration audits weekly.	

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F 759	Continued From page 106	F 759		

dresser next to R23's bed. LPN-C donned gloves, then opened an alcohol swab and cleansed the connection on the PICC line access for about 5 seconds. LPN-C connected the smaller tube to the site and pushed the medication into R23's PICC line. After removing the first syringe from the access, LPN-C opened a second alcohol swab and again cleansed the PICC access, for approximately 5 seconds, and then connected the larger medication tube to the access. As LPN-C finished pushing the medication into the access, she looked up. The surveyor asked which medication she was administering. LPN-C stated she had put the Heparin in first, and she now just gave the saline. LPN-C stated "I got nervous and I mixed up the order, and should have flushed the line with the saline first." LPN-C capped the PICC access, and disposed of the used medication syringes, removed her gloves and washed her hands, and stated she needed to immediately contact the doctor.

When interviewed on 12/12/18 at 2:04 p.m. licensed practical nurse (LPN)-C stated I put R23's heparin in first, I just realized it, I screwed up. LPN-C stated R23's order was for "SASH" which was a saline flush, then the antibiotic, then after the antibiotic finished to flush the PICC with saline, then the last step was Heparin for the lock. LPN-C stated she goofed up on the order, "its a med (medication) error."

During interview at 4:02 p.m. on 12/14/18, registered nurse (RN)-A discussed R23's medication administration error, and stated the nurse should have flushed the PICC line with saline first, then do the heparin lock. RN-A stated R23's physician was notified and there were no

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F 759	Continued From page 107 new orders regarding this, and we were directed to monitor R23 for any adverse reaction. R8's quarterly MDS dated 12/20/18, identified R8 was cognitively intact. The MDS identified a diagnosis of renal insufficiency and R8 was receiving dialysis services. R8's physician's orders signed 12/7/18, identified R8 was to receive Nephrocaps capsule 1 mg (B Complex-folic acid) one time a day in the afternoon for end stage renal disease. On 12/12/18, at 7:45 a.m. during observation of medication LPN-F put one capsule of Nephrocap 1mg into a medication cup. The Medication Administration Record (MAR) was reviewed with LPN-F and stated the MAR instructed the staff to give the Nephrocap in the afternoon at 2:00 p.m. LPN-F stated she would need to clarify the order, but then administered the Nephrocap to R8 without clarifying the order. Immediately after the nephrocap was given, LPN-F checked the physician order with RN-A who stated the order was to be given in the afternoon and was entered into the computer [MAR] at the wrong time. RN-A would be correcting it immediately. RN-A further stated the medication was given at the wrong time and would be considered a medication error. She would update the physician and family and complete an medication error report. A policy addressing medication administration was requested, but none was provided.	F 759		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)	F 810		1/26/19

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F 810	Continued From page 108 §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment to promote independence with eating for 1 of 1 residents (R25) who required adaptive devices. Findings include: R25's quarterly Minimum Data Set (MDS) dated 10/17/18, identified R25 required extensive assistance for eating. R25's Diagnosis Report, dated 12/13/18, identified diagnoses including vascular dementia without behavioral disturbance, cerebral palsy, dysphagia, and history of traumatic brain injury. R25's care plan revised 7/30/18, identified R25 was to maintain a current level of function in activities of daily living (ADL), including eating. Interventions included use of weighted spoon and C-plate, along with assistance from staff. R25's undated nursing assistant care sheets identified R25 was to use a scoop plate and to offer built up silverware at meals. During observations on 12/10/18, at 5:30 p.m., R25 was seated in her wheelchair in the third floor dining room at a table by herself. R25's meal ticket identified R25 was to have a scoop plate and built up silverware. R25 was served pulled	F 810	1.R25's adaptive equipment has been reviewed and the plan of care updated as indicated. 2.All residents who require adaptive equipment to promote independence have the equipment available. 3.Staff education has been completed to ensure adaptive equipment is being utilized per plan of care including education to ensure that all refusals of adaptive equipment is documented in the medical record. 4.DON/designee to complete 3 audits regarding adaptive equipment weekly. Audits will be brought to QAPI for review.	

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F 810	Continued From page 109 beef sandwich and soup on a scoop plate. Staff cut up the sandwich and assisted R25 in eating her meal with regular silverware. R25 was not provided built up silverware to aid in independence with eating. When interviewed on 12/10/18, at 5:55 p.m., licensed practical nurse (LPN)-C stated she believed the built up silverware was discontinued because R25 did not like it. When interviewed on 12/10/18, at 6:04 p.m. registered dietician (RD)-B and nurse consultant (NC)-A verified R25's care plan indicated the use of built up silverware. The RD-B stated she would refer R25 to occupational therapy related to refusal to use adaptive equipment. R25's medical record failed to indicate R25's refusal to use the recommended adaptive equipment or identify a referral was made to reassess R25's built up silverware. When interviewed on 12/14/18, at 11:44 a.m. director of nursing (DON) stated she expected staff to document rejection of care in the electronic health record. Facility policy titled Restorative Nursing Program, undated, indicated the facility would provide interventions to promote resident's ability to adapt and adjust to living as independently as possible; the policy did not specifically address the use of adaptive equipment.	F 810		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		1/26/19

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F 880	Continued From page 110	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 111 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely recognize and act on a potential norovirus outbreak and ensure appropriate precautions were in place and consistently implemented to prevent the spread of infection for residents for 14 of 50 residents (R62, R27,R37, R58, R36, R59, R44, R34, R59, R18, R22, R25, R35 and R51) who were exhibiting gastro-intestinal symptoms . This had the potential to affect all 62 current residents, staff and visitors to the facility. In addition, the facility failed to ensure proper handwashing and gloves usage was implemented for 3 of 3 residents	F 880	1.All residents mentioned that experienced gastro-intestinal symptoms have been asymptomatic and symptoms are resolved. All residents affected by GI symptoms were removed from precautions according to Minnesota Department of Health recommendations. No new symptoms of GI infection present at this time. Residents will have cares provided including proper handwashing and glove usage as appropriate during cares and treatments. 2.The facility has established and is	

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F 880	Continued From page 112 (R56, R15, R25) observed during personal care. Findings include: LACK OF APPROPRIATE RESPONSE TO GASTRITIS POSSIBLE NOROVIRUS OUTBREAK: During observation at 1:45 p.m. on 12/10/18, the west side of the 4th floor, several dressers were located on both sides of the hallway, located outside each of the following rooms: 414, 402, 404, 407, 415, 403 and 406. The wooden dressers, each about 2 & 1/2 feet high, 2 feet wide and 3 feet long, were worn, had scuff marks and unvarnished surfaces. Inside the drawers were packages of personal protective equipment (PPE), including yellow-colored gowns, blue face masks, and boxes of gloves of various sizes. The presence of the PPE in the dressers identified residents were in precautions. On top of each dresser was a laminated, orange-colored sheet from Washington State Hospital Association, revised 4/16/09. Printed on the front side were two "Stop" signs, and in bold print: "Droplet Precautions (in addition to Standard Precautions)." Also printed on the sheet, with accompanying icons: Everyone must: Clean hands when entering and leaving room; Wear mask; Doctors and staff must: If contact with secretions likely, use gown, glove and eye cover. The back side was labeled "Droplet Precautions," and included other directives, including: use dedicated or disposable equipment when available; clean and disinfect reusable equipment prior to removing from the room; bag linen in patient's room. During interview at 3:06 p.m. on 12/12/18, the	F 880	maintaining its infection prevention and control program, including Infection Preventionist reviewing concurrent and retrospective data on a regular basis for early recognition of potential infections. Upon identification of an infection, infection control surveillance will be completed, including reporting and investigation of communicable diseases. Preventative measures will be reviewed and updated as indicated with appropriate staff. 3.STaff have been educated on infection prevention and control program, including daily surveillance review completed to identify possible communicable diseases and infections using McGeers criteria for patient infection report forms. These forms will be reviewed by the IP to identify any necessary interventions, and added to the monthly IC log for follow up and data collection. Education was also completed on hand washing, PPE, and glove usage. 4.DON/designee to audit hand washing and glove use 3x/week, including auditing of PPE equipment 3x/week. DON/ designee will monitor residents and staff for infection symptoms with potential for transmission to ensure appropriate precautions are implemented timely. Audits will be brought to QAPI for review.	

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director of nursing (DON) stated they had recent 'GI' (gastro-intestinal) symptoms in December. The facility had been free of any widespread inspection or symptom outbreak. The DON stated beginning on 12/8/18, "a couple of residents" complained and had symptoms "of just not feeling well," and were on the same side of the nursing home. The DON said then more residents on the same unit then began having the same signs "and we tripped the threshold" meaning it looked like there were more things going on they realized.

A facility document, Resident Gastroenteritis Line List, December 2018, was reviewed. The line listing form provided room to list resident's name and room number; a section to mark various items, including: various symptoms; (nausea, vomiting, diarrhea, abdominal cramping, fever, chills); onset date and time; precautions initiated; date of last symptoms & time; dated precautions lifted. The line listing form was completed for each of the nursing home floors, and identified the following:

4th Floor:
1. R62; nausea, diarrhea; onset 12/8; last symptoms 12/11
2. R27; nausea, vomiting; onset 12/10;
3. R37; nausea, diarrhea; onset 12/8; last symptoms 12/10; precautions lifted 12/12
4. R58; nausea, vomiting, diarrhea; onset 12/8; last symptoms 12/9; lifted 12/12
5. R36; nausea, vomiting, diarrhea; onset 12/8; last symptoms 12/9; lifted 12/12
6. R59; diarrhea; onset 12/9; last symptoms 12/9; precautions lifted 12/12
7. R44; nausea, diarrhea; onset 12/7; last symptoms 12/9; precautions lifted 12/12

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F 880	Continued From page 114 8. R34; vomiting, diarrhea; onset 12/11; 9. R59; nausea, diarrhea; onset 12/13 (listed for 2nd time) 10. R18; vomiting; onset 12/14/18 at 6:00 p.m. 11. R22; diarrhea; onset 12/14/18 at 8:00 a.m. 3rd Floor: 1. R62, nausea, vomiting, diarrhea; onset 12/8; (R62 was moved to 4th floor) 2. R25 diarrhea (x 1); onset 12/10 2nd Floor: 1. R51 vomiting; onset 12/14, 6:30 a.m. Review of Employee Infection Line List/Log dated December 2018 identified the following employee absences and symptoms or complaints: -12/3 [registered nurse (RN)-B]; "general malaise: -12/4 [RN-B]; "general malaise" -12/7 [licensed practical nurse (LPN)-G]; "vomit, no diarrhea, ? taco" -12/13 [RN-C]; p.m. shift; "vomiting" -12/14 [nurse consultant (NC)]; a.m. shift; "vomiting" -12/14 [administrative support (AS)-A]; a.m. shift; "vomiting" -12/14 [LPN-H]; am shift; "vomiting" Additional observations and interviews on the 4th floor of nursing home identified the following: -12/10/18 at 7:18 PM during observation, a medication cart was parked near the 4th floor nurses station, and yellow-colored isolation gowns found in the attached open waste container. -12/12/18 at 9:16 a.m., R59 (identified with	F 880		

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precautions) had her call light on. Housekeeper (HSK)-A donned a face mask and entered R59's room. In the room, HSK-A picked up R59's TV remote off the floor, with un-gloved hands, and gave the remote to R59, then exited room. HSK-A then removed the mask and gloves outside of R59's room, and sanitized her hands. When interviewed at 9:19 a.m. HSK-A, when asked about glove usage and disposal of the mask, stated she should have taken the mask off in R59's room, and "I just didn't, but should have" worn gloves. HSK-A did not wash her hands and was unaware she needed to do this since she sanitized her hands.

-12/13/18 at 3:15 p.m., during interview, LPN-I stated that she just came on her shift and wasn't sure who was sick. Stated that during report she was told residents that were sick and throwing up needed to be on clear liquids and staying in their room but nothing else. Stated she thought that (R34, R36, and R58) were sick and they were "supposed to gown and glove for precautions" but added, "I am not sure" why they were on precautions. LPN-I stated cleaning was to be done with the "blue top" (bleach wipes which are effective for norovirus), "but were all locked up in the medication carts, accessible only to the nurses with keys."

-12/13/18 at 3:17 p.m., during interview RN-A revealed that is the expectation that the equipment that goes in the room gets bleach wiped between residents. RN-A stated the NA "needs to find a nurse" to open the medication cart to get the bleach wipes each time. RN-A stated the wipes have bleach in them so they need to be locked up in the medication carts.

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-12/14/18 11:45 a.m., activities director reported resident holiday parties took place in facility yesterday afternoon, on each floor. The activity director had no knowledge that residents activites should be limited or eliminated during the gastritis event.

During interview on 12/13/18 at 2:55 p.m. the director of nursing (DON) talked about recent outbreak of resident GI symptoms and stated the facility was concerned if what the residents were having was possibly more serious, like norovirus out break. The DON stated residents began exhibiting symptoms, like nausea, vomiting and diarrhea, "over the weekend, on the 8th and 9th." On Monday (12/10) "I called MDH" (Minnesota Department of Health) and I pulled the "toolkit" (information for Norovirus in long-term care facilities). The DON stated she got a call back from MDH on the next day, as was asked if I was using the toolkit, and if they "began any tracking." The DON stated on Monday, "that is when we recognized and started the droplet precautions." The DON stated they stopped the planned transfer of residents from the 3rd to the 4th floor of the facility. The DON did acknowledged there had been resident symptoms before this past weekend, but took action after the weekend on Monday (12/10/18). The DON also stated since the first identification, there were additional residents who exhibited symptoms like diarrhea, and vomiting symptoms since the start of the survey.

The DON stated the facility tracked both resident and staff symptoms, and the health department wanted to be notified immediately if any dietary employee was ill. The DON stated one ill employee who worked in the kitchen and had

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been to the doctor and the facility had a note directing not to have that employee return to work for six days. The DON questioned if that employee had a GI problem but to date, they "had not been able" to verify that employee's illness status. The DON stated that they tried not to have staff work all over the building. The DON acknowledged one employee on the symptoms line list, LPN-G, worked "all over" the building. The DON stated the facility policy allowed staff to return to work 48 hours after being symptom free.

The DON stated on "that Monday" (12/10/18) she enlisted help to talk about what cleaning products were to be used, and stated "we educated staff" on gowning, masking and gloving, and we increased frequency of cleaning. The expectation was "housekeeping would step up their game," the DON stated, and that "staff would wear PPE," and the lifts cleaned when they come out of the infected residents' rooms, and there would be the blue wipes, the Clorox bleach wipes everywhere. The DON acknowledged there was confusion about the type of wipes staff were to use, and the accessibility of the proper wipes that should be used to clean equipment. The DON said she did not personally address cleaning in the kitchen or dining areas, and was not able to say if kitchen/dietary staff were asked to do any special, additional cleaning, or on-going cleaning in response to the increased resident symptoms of gastritis.

The DON talked about getting verification of possible Norovirus outbreak, and stated the toolkit suggested we get stool samples from 2 to 3 residents, and "we tried" getting them. The DON stated the first sample they sent in was not

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properly handled, it did not arrive at the lab in time; and a second sample we sent in was not labeled. The DON stated she wanted them to run the sample "just to see if we had norovirus," but they would not do that. The DON acknowledged they did not have any lab confirmation at this time.

The DON stated the facility initiated droplet precautions, and said "maybe I screwed up" about what precautions were put in place. The DON stated she felt she was educating herself and did plenty of research "to do the right thing" to protect the residents. The DON stated they felt "droplet precautions" were the correct, but also stated if norovirus was suspected, contact precautions should have been considered. The DON expressed frustration with not consistently implementing the precautions for the residents, including the donning and proper disposal of the PPE, and the inconsistency of the cleaning of the lifts. The DON stated they did educate residents and staff about keeping identified residents in their rooms, but stated these were not always consistently implemented. Also, there was no ongoing visual surveillance during this time to prevent further spread of infection.

Minnesota Department of Health, 2018-2019 Norovirus Toolkit, Checklist, identified outbreak control measures, among which included:
-monitor for resident illness and isolate while ill and for 72 hours after symptoms have stopped;
-redouble efforts to promote glove use and hand hygiene;
-immediately clean/sanitize the facility, focus on frequently touched surfaces;
-strong bleach solution mixed fresh daily: 1 gallon water + 1/3 cup bleach;

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F 880	Continued From page 119 -clean and sanitize all kitchen and dining area surfaces with a product described above; -use appropriate PPE; -postpone of cancel common events such as birthdays, holiday until conclusion of the outbreak Centers for Disease Control (CDC) Guideline for Isolation Precautions, Preventing Transmission of Infectious Agents in Health Care Setting, dated 2007, indicated contact precautions were "to prevent transmission of infectious agents spread by direct or indirect contact with the patient or the patient's environment." Contact precautions directed caregivers to wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient environment, and donning PPE upon room entry and discarding before exiting the patient room is done. A facility policy, Infection Control Outbreak Management, Management of Norovirus Outbreaks, dated 2015, indicated that once loose, watery stools have been evaluated, prevention and outbreak management measures must be followed. Numerous interventions were identified: Under Early Control Measures: The infection control staff should be immediately notified about he onset of the first case; reinforce contact precautions; reminding staff that proper hand washing after all patient contact (washing with warm running water and soap for at least 10 seconds); and potential cases should be confirmed as soon as possible; symptomatic residents should be a cohort. Under Control of Transmission at the Ward/Unit Level: Gloves, masks and gowns should be worn	F 880		

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whenever contact with an infected resident or contaminated environment is anticipated.

Under Prevention of Spread to Other Areas: Restrict staff movement between ward, especially into infected areas; and whenever possible, essential staff should be dedicated to the infected areas only. Transfers of residents from affected wards to other departments should be prohibited unless medically necessary.

Under Cleaning and Disinfection: Immediate cleaning and disinfection of contaminated areas area vital in controlling the spread of norovirus. It is essential that those responsible for cleaning and disinfecting contaminated surface have adequate protective clothing and equipment to minimize the possibility of spread among staff. Contaminated and potentially contaminated linen and removable fabrics should be immediately and carefully collected in plastic garbage bags and laundered. Exposed consumables should be discarded.

HANDWASHING/GLOVE USAGE
R56 admission Minimum Data Set (MDS) dated 11/23/18, indicated R56 was cognitively intact and required assistance with cares.

During observation on 12/11/18, at 8:57 a.m. NA-G with clean gloves cleansed R56's peri-area after being incontinent of urine. NA-G removed his soiled gloves, and immediately doned clean gloves without first washing his hands. NA-G then applied barrier cream to abdominal folds, peri-area then to legs. NA-G again removed his soiled gloves, and did not wash his hands prior to applying clean gloves. NA-G removed soiled bedding that had been soaked with urine, and

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cleaned mattress with wet paper towel and soap. He then removed his soiled gloves, and without first washing his hands placed clean bedding on R56's bed.

When interviewed on 12/12/18 at 9:27 a.m. NA-G stated hands he was to wash his hands every time gloves are changed when providing cares. NA-G acknowledged he had not washed his hands and should have been done to prevent the spread of infections.

R15's annual Minimum Data Set (MDS) 6/28/18, indicated R15 was severely cognitively impaired, required extensive assistance for activities of daily living (ADL).

During observation of personal cares on 12/13/18, 6:27 a.m. R15 was lying supine in bed, her arms crossed over her chest with her entire body exposed, blanket balled up on far side of bed. NA-E had gloves on and was cleaning front perineal area with wet wash cloth. NA-E disposed of wet washcloth into a plastic bag located on the floor, he grabbed a dry towel and patted perineal area dry. NA-E disposed of R15's soiled brief in a plastic bag and placed the bag on the floor. NA-E continued to provide cares with his soiled gloves, dressing R15's in a sweatshirt and jeans. He then positioned hoyer sling under R15, pulled the blanket onto her body, lowered R15's bed to floor, positioned a safety mattress on the floor near R15's bed, moved the dirty brief bag to an area under the sink. NA-E then removed his soiled gloves and without washing his hands left the room and returned with NA-H and a hoyer lift. NA-H washed her hands, donned gloves, and electronically raised R15's bed. NA-E with his

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soiled hands, positioned a wheelchair near the hoyer and then placed socks on R15's feet and transferred R15 out of her bed and into her wheelchair.

NA-E then left the room without first washing their hands and returned with tooth brush, toothpaste, toothette and emesis basin. NA-E set the oral care supplies on the counter and donned gloves. NA-E brushed R15's hair, placed the hair brush on the counter, removed his gloves and washed his hands. NA-E stated he was leaving the room again to get a towel and wash cloth. NA-E returned to the room and donned gloves. He opened a drawer and put R15's hair brush in the drawer. NA-E placed a towel over R-15's chest, put toothpaste on a tooth brush and attempted to brush R15's teeth, with resident refusing. NA-E then attempted to perform oral cares with a foam toothette. R15 again refused to open her mouth and pushed NA-E's hand away from her face. NA-E disposed of foam toothette, removed his gloves and without washing his hands donned new gloves. NA-E removed the soiled wash cloth and towel from R15 chest. He retrieved a sock from the floor and put the sock back on R15's foot. NA-E then stated he had completed cares and would wheel resident to breakfast.

During interview on 12/13/18 7:05 a.m. NA-E stated before doing cares each morning he gathers all the items he needs and brings them when he enters a room. NA-E stated he washes his hands and puts on gloves when he starts his cares. When he completes cares he steps away, removes his gloves and washes his hands. NA-E stated he was unaware he had not washed his hands or changed his gloves during R15's cares.

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F 880	Continued From page 123 When interviewed on 12/13/18, at 1:21 p.m. director of nursing (DON) stated the staff were instructed to perform hand hygiene after removing gloves, especially when in contact with bodily fluids. R25's was observed on 12/12/18 at 7:07 a.m., during morning cares. NA-A had gloves on and completed front personal cares for incontinence. Without first removing her gloves or washing her hands she touched R25's pillow, then removed her gloves,and washed her hands, and applied new gloves. NA-A assisted R25 to roll onto her side and completed personal cares to R25's bottom. NA-A then placed a Tubi-grip (sleeve to protect fragile skin) to R25's right leg, a total lift sheet under her, placed her shoes on, touched her pillow along with moving a pillow, and touched the bed control with her soiled gloves. NA-A then removed her soiled gloves and left the room without first washing her hands. When interviewed on 12/14/18 at 11:44 a.m., the director of nursing (DON) expectation was staff were to perform appropriate hand hygiene and change gloves between tasks. A facility Infection Control Glove Technique policy dated 2015 indicated Remove gloves promptly after use and wash hands immediately to avoid transfer of microorganisms.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		1/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 12/17/2018

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F 921	Continued From page 124 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to provide safe, uncluttered environment on the north hallway of 4th floor reviewed for 2 of 2 residents (R50, R57) who voiced concern over the crowded hallway. This had the potential to affect all 26 residents who resided on the 4th floor. Findings include: On 12/11/18, at 8:42 a.m. the 4th floor North hallway was observed with a medication cart, two mechanical lifts, housekeeping cart, three wheelchairs, a walker, three isolation carts, and an electronic vitals machine on the left side of the hallway. At the same time the right side of the hallway contained a medication cart and two isolation carts. R50 was in an electric wheelchair and had to wait for the nurse passing medications to move the medication cart so he could get through the narrow passageway in the hallway. R50 was further observed weaving amongst the items in the hallway to the end of the hallway to the window. A breakfast cart was seated in the middle of the hallway when R57 was coming back from the dining room wanting to go to his room, he pushed the cart out of his way to get through the halls and had to back up approximately 20 feet to allow R50 to pass in the hallway. R50 complained to registered nurse (RN)-A stating, "you can't put stuff on both sides of the hallway or they can't get through". RN-A responded that she "couldn't help	F 921	1. R50 and R57 can independently maneuver in the hallways. 2. The North hallway of 4th floor has been cleared of clutter. LNHA has met with residents to ensure residents can maneuver independently in the hallways. 3. Staff have been re-educated regarding keeping hallways free of clutter, including proper of equipment. Equipment being utilized will be placed on one side of the hallway to allow safe and functional passage. 4.LNHA/Designee will audit 3x week hallways to ensure they are free of clutter; including observations of residents maneuverability and resident interviews. Audit results to be reviewed at QAPI.	

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F 921	Continued From page 125	F 921		

it right now" but did take the med cart to the South hallway but all other items remained as obstacles in the hallway.

On 12/11/18, at 3:21 p.m. the 4th floor North hallway had four isolation dressers on right side of hallway, nursing assistant (NA)-D had a cart holding water pitchers. The left side of the hallway contained one medication cart, three isolation carts, two wheelchairs, a walker, three lifts, and a vital sign machine. R57 was walking independently with the use of a cane and right hand splint on while using the handrail for stabilization. He was maneuvering around the obstacles in the hallway unable to use of the handrail for balance. R57 stated, "it was hard walking around all of the stuff in the hallways. I tell them but they still do it all the time".

On 12/12/18, at 7:55 a.m. the 4th floor North hallway contained three isolation carts on right side and a vitals machine, four isolation carts, one med cart, walker, three lifts, two wheelchairs on left side of hallway. Residents were returning from breakfast but needed to back up to allow another residents to get through. The obstacles only allowed for one way walking and wheelchair traffic.

On 12/12/18, at 2:12 p.m. the 4th floor North hallway had two isolation carts on the right side of the hall way with one med cart, three lifts, one walker, one vital sign machine and two wheelchairs on the left side of the hall way. R57 in wheelchair pulling himself along the handrail in the hallway has to maneuver around the carts.

The facility Resident Listing Report printed 12/10/18, identified 26 residents resided on the

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	245186	A. BUILDING _____ B. WING _____	C 12/17/2018

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F 921	Continued From page 126 4th floor. Villa Healthcare Resident Right policy with effective date of 11/28/17, indicated the residents have the right to a safe, clean, comfortable, and home-like environment that allows independence as possible.	F 921		

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	245186	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/20/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 20, 2018. At the time of this survey, Brookview A Villa Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Brookview A Villa Center is a 3-story building with a partial basement that was constructed in 1972 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 104 beds and had a census of 63 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.