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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: J99U
Facility ID: 00103

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245344**
2. STATE VENDOR OR MEDICAID NO. (L2) **134240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW CARE CENTER**
(L4) **702 10TH AVENUE NORTHWEST, PO BOX 10**
(L5) **DODGE CENTER, MN** (L6) **55927**

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)
6. DATE OF SURVEY **12/24/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X 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
	55			
(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 :
Maria King, Manager 01/02/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 01/02/2019 (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)

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
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245344

January 2, 2019

Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, MN 55927

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 November 28, 2018 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 2, 2019

Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, MN 55927

RE: Project Number S5344031, H5344025

Dear Administrator:

On November 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 26, 2018 that included an investigation of complaint number H5344025. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 10, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2018.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2018, effective November 28, 2018 and therefore remedies outlined in our letter to you dated November 14, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00103

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2. STATE VENDOR OR MEDICAID NO. (L2) **134240100**

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(L3) **FAIRVIEW CARE CENTER**
(L4) **702 10TH AVENUE NORTHWEST, PO BOX 10**
(L5) **DODGE CENTER, MN** (L6) **55927**

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)

6. DATE OF SURVEY **10/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
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* Code: (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Kyla Einertson, HFE NE II 11/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/14/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **10/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

November 14, 2018

Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, MN 55927

RE: Project Numbers S5344031, H5344025

Dear Administrator:

On October 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 26, 2018 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5344025.

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 December 5, 2018.

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:

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

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 January 26, 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 April 26, 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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING ______ B. WING ______	C 10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927

(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 October 22, 23, 24, 25 & 26, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On October 22, 23, 24, 25 & 26, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Also a complaint investigation(s) were completed at the time of the standard survey. An investigation of complaint H5344025 was completed. The complaint had been substantiated and deficiencies were cited at F689. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		11/28/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING ______ B. WING ______	C 10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 550	Continued From page 1	F 550		

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING ______ B. WING ______	C 10/26/2018

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FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a dignified dining experience for 4 of 4 residents (R25, R39, R40, R202) observed during an evening meal. Findings include: R25's quarterly Minimum Data Set (MDS) dated 9/19/18, indicated R25's cognitive skills for daily decision-making were severely impaired. The MDS further indicated for eating R25 required limited assistance from one staff. R25's care plan dated 9/10/18, indicated R25 was independent with eating, and at times needed encouragement to eat. R39's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R39 had no speech, rarely/never made self-understood and rarely/never understood others. The MDS further indicated R39's cognitive skills for daily decision-making were severely impaired and for eating required extensive assistance from one staff. R39's care plan dated 9/17/15, indicated R39 required total assistance with meals and was at risk for aspiration. R40's admission Minimum Data set dated 10/4/18, indicated cognitive skills for daily decision-making were severely impaired. The MDS further indicated for eating R40 required extensive assistance from one staff. R40's care plan dated 10/25/18, directed staff to provide total feeding and to feed R40 slowly. The care plan also indicated R40 had a history of dysphagia (difficulty swallowing) with mild pocketing of food	F 550	Deficiency with ID Prefix Tag F550 shall be corrected. Facility shall ensure a dignified dining experience for all residents during the evening meal. Table placement with staff assistance for R25, R39, R40 and R202 has been evaluated to ensure each resident at the table receives necessary assistance with their meal in a dignified manner. Evaluation looked at level of assistance required by each resident and assignment of staff to ensure the assistance is appropriately provided. Table placement for all residents who eat in the assisted dining room has been evaluated to ensure all residents receive necessary assistance with their meal in a dignified manner. Evaluation looked at level of assistance required by each resident and assignment of staff to ensure the assistance is appropriately provided. All nursing and dietary personnel shall be reeducated on the dining experience for residents and ensuring that it is accomplished in a dignified manner. The re-education shall include ensuring assistance is offered and provided to resident when the plate is presented (Cutting food, buttering, placement of items, etc.), and to stay seated next to residents requiring assistance with the exception of a safety risk situation that could occur. This Plan of Correction shall be monitored for continued compliance by the Director of Nursing and/or the Dietary Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 550	Continued From page 3 and R40 would eat in the assisted dining room for help and observation during meals. During the dinner observation on 10/22/18, at 5:37 p.m. R25 sat alone at a table adjacent to the table where R39, R40, and R202 sat in there wheelchairs. Nursing assistant (NA)-C sat next to R39, clinical nurse manager registered nurse (RN)-B stood next to R40 while giving her bites of food, and NA-D sat next to R202 and was giving him bites. At 5:42 p.m., RN-B walked away from helping R40 to eat and R40 made no attempt to feed herself. At 5:43 p.m., NA-C stopped feeding R39, sanitized his hands, walked over to R25's table, kneeled next to her, cut up her peaches, and encouraged her to take a bite. R25 had been attempting to eat her soup, however, was not able to get the spoon all the way into the bowel an no help was provided. At 5:43 p.m., NA-D stood up and provided R40 with a bite of food, then sat back down to give R202 a bite of food. At 5:44 p.m., NA-D again stood up and provided a couple of bites of food to R40. At 5:45 p.m., NA-D sat back down and resumed feeding R202. At 5:45 p.m., NA-C returned to R39 four minutes later at 5:47 p.m. and gave her a drink. At 5:48 p.m. R25 struggled to eat her food; missing the bowel with her spoon, and attempted to cut lettuce with her spoon and no staff assistance noted. At 5:48 p.m., NA-D stopped feeding R202 and walked to the hand sink on the other side of the dining room. An unidentified aide stood next to	F 550	through direct observation of 3 randomly selected meals per week for a month. Findings shall be reviewed at the January, 2019 QAPI meeting.	

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F 550	Continued From page 4 R40 and gave her a bite of food then walked to the hand washing sink. Director of nursing (DON) then sat down next to R40. At 5:49 p.m. NA-D sat down next to R202 and resumed assisting him to eat. At 5:50 p.m. R25 continued to try and cut her lettuce with her spoon, tomato was on the floor. R25 brought her spoon to her mouth repeatedly; however, nothing was on it. Again no staff assistance noted. At 5:51 p.m. NA-C stopped feeding R39, walked over to a resident at another to table to provide verbal cues to sit down. NA-C returned to assist R39 two minutes later at 5:53 p.m. At 5:52 p.m. NA-D stopped assisting R202, and walked over to R25. NA-D cut up the lettuce on R25's plate. DON asked R202 if he was done eating; R202 responded "no" however, there was no staff at the table to assist him until 5:55 p.m. when NA-D returned to the table. At 6:01 p.m. NA-C stopped assisting R39 and walked away from the table and left the dining room.R39 was not provided assistance again until nine minutes later when NA-D returned to help her. During an interview on 10/22/18, at 6:16 p.m. NA-C stated R25 required variable amounts of assistance during meals from supervision to total assist. NA-C indicated it wasn't "ok" or dignified to get up and leave a resident to assist another resident during the meal; however sometimes the need arises like when a resident is attempting a self-transfer. NA-C further indicated there was enough staff in the dining room to assist and	F 550		

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F 550	Continued From page 5 provide a dignified dining experience to all of the residents who required staff assistance to eat. During an interview on 10/22/18, at 6:22 p.m. NA-E indicated it was not dignified to standup while assisting residents to eat and/or walk away from a residents while assisting them to eat. During an interview on 10/25/18, at 8:48 a.m. DON stated NA's should stay seated next to the resident they are assisting to eat throughout the meal to provide a dignified dining experience.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		11/28/18

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F 561	Continued From page 6 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights 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 ensure choice of arise time and bedtime for 2 of 2 residents (R18 and R24) and failed to ensure choice of preferred consistency of liquids for 1 of 1 resident (R15), reviewed for choices. Findings include: R18's quarterly Minimum Data Set (MDS) an assessment, dated 8/29/18, indicated R18 was cognitively intact and required one assist with dressing. During interview on 10/22/18, at 7:12 p.m., R18 stated he does not get to go to bed at night when he wants to. R18 stated he would like to lay down right after supper. R18 said between 6:30 p.m. and 7:00 p.m. would be the ideal time to go to bed. During observation on 10/23/18, at 2:50 p.m., R18 was in bed watching T.V. R18's sleep document, dated 8/29/18, indicated what time do you usually go to bed. Between 9 to 10 p.m. R18's current care plan indicated R18 needed one staff assist for dressing. The care plan lacked to include the time R18 preferred to go to bed.	F 561	Deficiency with ID Prefix Tag F561 shall be corrected. Facility shall ensure choice of arise time, bedtime and preferred consistency of liquids for all residents. The Care Plans and CNA pocket care plans for R18 and R24 have been updated to include preferred arise and bedtimes. All resident care plans and CNA Pocket Care Plans have been updated to reflect chosen arise time and bed time. The Clinical Nurse Manager met with R15 to discuss her choice in the consistency of her liquids. The CNM reviewed all risks and benefits and resident states she wishes to stay with her current consistency of liquids. Resident understands this is her choice. All residents are informed that they have the right to self determination and choice in all aspects of their life and all staff will encourage residents to make choices and honor these choices. Nursing personnel shall be reeducated on the residents right to choose when to get up and when to go to bed and location of time choice being indicated on the care plan. Nursing, Dietary and Activity personnel shall be reeducated on proper consistency preparation of thickened liquids. This plan of correction shall be monitored	

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F 561	Continued From page 7 During interview on 10/24/18, at 1:31 p.m., nursing assistant (NA)-G stated she did not know what time R18 preferred to go to bed at night. R24's significant change MDS, dated 9/19/18, indicated R24 was cognitively intact and required one assist with dressing. During interview on 10/22/18, at 4:50 p.m., R24 stated I like to go to bed at 9:00 p.m. and would like to get up at 5:00 a.m. I do not like to argue with staff when they chose to get me up and put me to bed. It depends on who is working. One staff member will get me up at 5:00 a.m., but if that person is not working, I have to stay in bed until 6:00 a.m. During observation on 10/24/18, at 7:10 a.m., R24 was dressed and seated in her wheelchair in her room watching T.V. R24's sleep document, dated 9/18/18, indicated what time do you usually go to bed was 9 p.m. and what time do you like to wake up in the morning was 4 a.m. to 5 a.m. R24's current care plan indicated R24 needed one staff assist for dressing. The care plan lacked to include the time R24 preferred to arise and go to bed. During interview on 10/25/18, at 10:59 a.m., registered nurse (RN)-B stated the choice of time arise and time to go to bed was asked on admission on the facility sleep assessment. RN-B confirmed the time of bedtime and the time of arise identified on the sleep assessments could not be viewed by the nursing assistants. RN-B stated R18's and R24's care plan lacked to	F 561	by the Director of Nursing/designee through direct interviews with residents regarding if they are getting up and going to bed as they choose. Five residents a week for a month shall be asked about their rise and bedtimes. Consistency of R15's liquids shall be monitored for correctness by the Dietary Manager or designee 3 times a week for a month. Findings shall be reviewed at the January 2019 QAPI Meeting.	

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include the time they prefer to arise and go to bed.

During interview on 10/25/18, at 1:21 p.m., the director of nursing (DON) stated she would expect the times identified on the sleep assessment for time arise and time of bed be carried over to the resident care plan.

A policy for choices was requested, but not provided.
R15's record, included a history of aspiration pneumonia but has a cognitive score of 14 out of 15 indicating only a slight cognitive loss.

During an interview on 10/22/18, 4:17 p.m. R15 stated that she didn't like the thickened liquids that were provided to prevent aspiration because they were "hard to drink" and did not quench her thirst. During that interview, R15 indicated an awareness of her risks of choking and possible aspiration pneumonia from consuming thin liquids, but voiced a willingness to take that risk when she feels thirsty.

A dismissal summary from R15's Mayo medical provider on 1/29/18- noted R15 has had several bouts with aspiration pneumonia with septic shock; however, a note written 7/16/18, by a Mayo Physician's Assistant said, "seen per resident request to progress to regular diet with regular liquids. ST [speech therapy] would like repeat swallow study. Order provided."

Swallow evaluation results dated 8/9/18, are as follows: "Moderate aspiration of nectar with spontaneous cough. No penetration or aspiration of honey or applesauce. Impression: moderate aspiration of nectar with spontaneous cough.

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Continued From page 9
The medical record does not show any change in recommendations for the resident in relation to her fluid consistency following this evaluation. On 1/31/18, Speech Therapy had recommended providing "honey thick liquids only", but had indicated on 7/3/18, that ice cubes made from water thickened to the appropriate consistency could be provided.

On 10/24/18, at 9:24 a.m. R15 was observed to be at the breakfast table with a glass of juice so thick it was sticking in clumps to the side of the glass. This was not consumed by the resident. No ice was seen.

According to an interview on 10/24/18, at 9:37 a.m. with nursing assistant (NA)- B, said that R15 had asked for thin liquids but NA-B tells her that staff are only allowed to give what is listed on the care plan. NA-B said that R15 seemed to understand her risk of aspiration and then said "[R15] doesn't like lukewarm fluids" and so NA-B makes a habit of getting water from the drinking fountain so it is "nice and cold." NA-B stated that to her knowledge, R15 could not have ice cubes.

10/24/18, 10:26 a.m. activities director showed ice cubes made of thickened fluids that are available to resident and confirmed that R15 does prefer chilled beverages to be quite cold.

On 10/24/18, 11:01 a.m. R15 was observed sitting in the day room with glass of thickened water that appeared thicker than a honey consistency, it was clumped and sticking to the edge of the glass. NA-A said in passing, "she [thickened water] is pudding thick." R15 said, "it's really thick, I don't like it," but attempted to drink it. Because of the thickness it did not flow well to

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her mouth. R15 made a face and said, "I don't like the taste of this" and did not drink any more of it.

During an interview, 10/24/18, at 11:06 a.m. NA-A stated that R15 is to receive "pudding thick" fluids. When asked how staff know what thickness R15 should receive, NA-A replied, "because I have worked here a long time."

10/24/18, at 11:33 a.m. R15 was observed in the dining room with juice that is pudding consistency. No ice was seen.

10/24/18, at 11:12 a.m. speech therapist (SLP)was interviewed about R15's thickened liquids. SLP said R15 had not been on the case load for a while but knew there were no new recommendations for R15 and she should receive honey thick liquids and could have ice cubes made from the same honey thick liquids. SLP also stated that they had done training for all staff in the facility within the last month and posted information throughout the facility on how to correctly thicken liquids. These posters were observed as posted.

When interviewed on 10/24/18, at 1:29 p.m. the clinical manager, licensed practical nurse (LPN)-B said she was unware that R15 did not like the ordered honey thickened liquids. LPN-B stated that the information about providing thickened liquids was on R15's care plan and was also listed on the nursing assistant care sheets. LPN-B confirmed that ice cubes made of thickened water were available for R15 to make the liquids more palatable and LPN-B stated assurance that the nursing assistants were aware they could use them. When informed that a

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nursing assistant had given R15 pudding thick fluids, LPN-B reviewed the care sheet and again confirmed that the correct physician order for honey thick liquids was on the sheet and that all nursing assistants are to refer to the care sheet in order to provide cares as planned.

According to an interview on 10/25/18, 9:34 a.m. the director of nursing (DON) was not aware that R15 had expressed her dislike of thickened liquids to any staff person. When asked about the protocol should a resident disagree with recommendations made for diet or altered fluid consistency, DON said they would educate the resident and if needed, would get ST involved. Should a resident continue to disagree with recommendations, the facility would offer a "shared risk agreement" to show the person understands their risk, but prefers not to follow the recommendation. DON stated that R15 had such an agreement in the past, but she is unsure if she has one currently. DON also stated a belief that R15 and nurses know that such an agreement can be completed if requested.

10/25/18, 11:39 a.m. R15 was observed in the dining room with cocoa thick enough to mound up on a spoon--pudding thick.

R15's current physician orders indicated her fluid order is "honey thick."

R15's care sheet was reviewed and had not indicate that ice-cubes of thickened liquids can be used.

Policy for thickened liquids asked for and none recieved.

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F 607	Continued From page 12	F 607		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their abuse prohibition policy and procedures failed to identify appropriate reporting procedures and guidance for resident-to-resident altercations according to the definitions of abuse outlined in federal regulation at F600. This could affect most residents in the facility. Findings include: The facility policy Abuse Prohibition and Prevention policy dated 11/28/16, included: "All residents have a right to be free from abuse, neglect, misappropriation of resident property and exploitation. It is the policy of Fairview Care Center to ensure that each resident is free from abuse, neglect, misappropriation of resident property and exploitation". The facility policy directed staff that all alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and	F 607	Deficiency with ID Prefix Tag F607 shall be corrected. Facility shall ensure the Abuse Prohibition Policy and Procedures identify appropriate procedures and guidance for resident to resident altercations according to the definitions of abuse outlined in federal regulation F600. No resident was effected by this deficiency. One resident-to-resident altercation was reviewed during the survey and it was reported appropriately. The Resident-to-Resident Policy and Procedure has been reviewed and updated to reflect proper reporting requirements including the statement "regardless of whether the individual intended to inflict injury or harm". Flowsheet dated 6/2013 was removed from the Resident to Resident Altercation Procedures. Employees responsible for reporting have been educated on this Policy and Procedure.	11/28/18

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F 607	Continued From page 13 misappropriation of resident property, are immediately reported immediately with the following guidelines: 1) Within 2 hours for allegations that involves abuse or serious bodily injury, 2) within 24 hours for allegations that does not involve abuse or serious bodily injury the police indicated Resident to Resident altercations were only reportable to the Stage Agency that result in the infliction of injury, unreasonable confinement intimidation or punishment with resulting physical harm, pain, or mental anguish. This is the state maltreatment definition. Facility flow sheet for Resident-To-Resident Altercations dated 6/2013, asked, "Did the resident act willfully in the altercation?" and included the definition of "willful" as the individual intended the action itself that he/she knew or should have known could cause physical harm, pain or mental anguish. Even though a resident may have cognitive impairment, he/she could still commit a willful act. The flow chart directed staff that if the willful act did not result in physical harm, pain, or mental anguish, the act was not reportable. The State Operations Manual (SOM) Appendix PP dated 11/22/17, defined the definition of willful as, "used in this definition of abuse, means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm. During an interview on 10/25/18, at 2:40 p.m. administrator verified the reporting procedures in the facility abuse prohibition policy and indicated the facility would follow the reporting requirements as defined by the Federal reporting	F 607	The Administrator shall monitor this plan of Correction for continued compliance by reviewing each resident to resident altercation over the next three months to ensure proper procedure was followed. Findings shall be reviewed at QAPI Meeting scheduled for January 2019.	

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F 607	Continued From page 14 requirements.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments by not identifying diagnosis of congestive heart failure (CHF) for 2 of 2 residents (R7, R21) reviewed for edema. Findings include R7's diagnosis list dated 10/25/18, lacked identification of diagnosis of congestive heart failure (CHF). R7's physician order dated 7/19/18, indicated required compression stockings below the knee for diagnosis of CHF. R7's physician visit note dated 8/1/18, indicated reason for visit was acute on chronic combined systolic and diastolic heart failure. The note also indicated R7 had a history of congestive heart failure in which Lasix (diuretic medication) was prescribed. R7's significant change Minimum Data Set (MDS) an assessment dated 8/1/18, lacked identification of CHF. R21's diagnosis list dated 10/25/18, lacked identification of diagnosis of CHF.	F 641	Deficiency with ID Prefix Tag 641 shall be corrected. Facility shall ensure accuracy of Minimum Data Set (MDS) assessments by identifying diagnosis of congestive heart failure (CHF). MDS's for R7 and R21 have been modified to accurately reflect diagnosis of CHF. All residents with a diagnosis of CHF have this accurately coded on the MDS. Both diagnosis were new after residents had been admitted. Clinical Nurse Managers will review all acute visit summaries from NP's and Physician and communicate any new diagnosis to the MDS coordinator for inclusion on the MDS. The Director of Nursing or designee shall randomly review NP and/or Physician notes from acute visits to ensure new diagnosis are included on the MDS. This will be done twice a week for a month. Findings will be reported at the January 2019 QAPI Meeting.	11/28/18

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F 641	Continued From page 15 R21's physician visit dated 10/2/18, and on 10/10/18, identified a plan for diagnosis of CHF. R21's quarterly MDS dated 10/12/18, lacked identification of CHF. During an interview on 10/25/18, at 8:28 a.m. director of nursing (DON) indicated R7 and R21 had diagnosis of CHF and the MDS should have reflected the diagnosis on the MDSs. During an interview on 10/25/18, at 10:08 a.m. registered nurse (RN)-A stated they were responsible for completing MDS's. RN-A verified R7's MDS dated 8/1/18, and R21's MDS dated 10/12/18, did not reflect the diagnosis of CHF and should have been identified. RN-A stated the diagnoses were omitted in error. Undated facility policy Completion of the RAI (Resident Assessment Instrument) included: Staff will complete the MDS sections assigned to them by resident assessment, resident interview, staff interview, and observation of the resident while performing routine activities. B) Staff my utilize information in the medical record to assist with completion of the MDS. This includes but is not limited to nurse's notes, physician progress notes, therapy notes, flow sheets, MARs/TARs, laboratory data, information provided by a hospital or other facilty. Information used for this purpose must fall within the look back period for each section as outlined in the RAI manual.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		11/28/18

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F 656	Continued From page 16 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 17 section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 resident (R45) reviewed for hearing impairment. Findings include: On 10/22/18, at 2:00 p.m. during an observation and interview R45 stated he has not had a hearing aid and stated it was missing. R45 stated he would like to get a new hearing aid. R45 was observed to not have hearing aids in place. R45 was re-admitted to the facility on 7/9/18, per the admission record with diagnoses of chronic gout and malaise. R45's care plan created date 6/16/17, with a revision date of 7/18/18, included, "Resident is very hard of hearing and has right hearing aid. Resident states he sees well and does not wear glasses. Resident accepted all In House Services." Goal dated 6/16/17 included: Resident will continue to see and hear well with current aides." Review of the admission Minimum Data Set (MDS) an assessment dated 7/16/18, identified R45 as utilizing no hearing aids for hearing. The resident had a BIMS score of "5" (meaning severely impaired cognition) and the resident was sometimes understood and understands. Cognitive/Communication/Hear/Vision progress note dated 7/9/18 included, "Late Entry: Note	F 656	Deficiency with ID Prefix Tag F656 shall be corrected. Interventions shall be developed on the person centered care plan to address hearing impairment. R45 will be getting new hearing aides. We are working with InHouse Audiology and they are currently waiting on an authorization from Mayo to be approved and POA signature before the hearing aids can be ordered. All other residents with hearing impairments will have their care plans reviewed to ensure interventions are developed. This Plan of Correction shall be monitored by the Social Worker for continued compliance with audits of new admissions and any resident with a new hearing impairment for one month. Findings will be reported at the January, 2019 QAPI Meeting.	

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F 656	Continued From page 18 Text: Resident is alert and oriented to self. Unable to state where he was at or the date. Resident communicates in English but is sometimes difficult to understand due to muffled speech. Resident does not wear dentures, and has no teeth left of his own. Resident is very HOH [hard of hearing] but does not wear hearing aids. Resident states he sees well and does not wear glasses." On 10/24/18, at 7:56 a.m. nursing assistant (NA)-A stated R45 did not wear hearing aids and stated she was not aware if he had hearing aids. NA-A stated the hearing aids would be listed on his cheat sheet and stated the cheat sheet for him did not indicate he had hearing aids. On 10/24/18, at 10:34 a.m. social services (SS)-A stated prior admissions to the facility a long time ago he had hearing aids. SS-A stated when he came back to us this admission, he did not having hearing aids. SS-A stated R45 was signed up for the audiology service and will be seen when they come to the facility next. SS-A stated R45's admit date to the facility for his current stay was 7-9-18, and verified R45's care plan indicated R45 had a right hearing aid. On 10/25/18, at 10:50 a.m. the director of nurses (DON) stated the clinical mangers are in charge of the care plan and we review care plans before their care conferences. The DON stated her expectation was when a resident was a readmission to the facility; the clinical managers are to review the care plan, to ensure they would be accurate for the current stay. The DON stated social services would write the dental, hearing and vision care plans. The DON stated R45's hearing care plan was last revised 7/18/18, by the	F 656		

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F 656	Continued From page 19 social worker. The Care Plan policy reviewed 12/4/13 included, "The care plan will address the needs, strengths, and preferences identified in the comprehensive resident assessment."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		11/28/18

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F 657	Continued From page 20 Based on observation, interview and document review, the facility failed to revise the care plan with fall interventions for 1 of 4 residents (R30) reviewed for accidents. Findings include: R30's quarterly Minimum Data Set (MDS) an assessment, dated 9/26/18, indicated R30 had severe cognitive impairment, required limited assist of one person for transfers and ambulation, had falls since admission, two with no injury and two with injury. R30's current care plan indicated Focus: resident is at risk for falls. See most current Faber Fall Risk Data sheet for details. Safety Checks due to resident history of frequent falls. Interventions dated 6/22/18, included Faber fall risk evaluation to be completed upon admission, after a fall, with a significant change, quarterly and as needed (PRN). Instruct/remind resident to use call light when needing assistance. Monitor resident for steadiness when ambulating. Staff to assure resident receives assistance when needed. Interventions dated 8/29/18, included provide distraction such as folding towels. Resident does not use wheelchair. Use walker at all times. While resident is sitting/lying, walker is to be out of walking path to prevent resident bumping into it and tripping/falling as resident does have poor vision. Resident wears hip protectors. When resident becomes restless, offer to go for a walk with assist of 1, Front Wheel Walker, and gait belt. Interventions added 9/14/18, indicted offer distractions when resident becomes impulsive, to include folding towels/clothes, conversing, going for a walk, participating in the day's activities, having a snack, etc. Cue/assist to toilet upon	F 657	Deficiency with ID Prefix Tag F657 shall be corrected. Resident care plans shall be revised to include fall interventions. R30's care plan has been updated to include fall interventions. All residents who are a fall risk have appropriate fall interventions identified on their care plan. Fall Policy has been reviewed and revised to ensure that new interventions are reflected on a residents care plan. Staff responsible for Care Plan development and revisions have been reeducated on the need to revise the Care Plan after a fall to include new interventions. The Director of Nursing or designee shall monitor this plan of correction for continued compliance by reviewing all resident falls and their care plan for one month to ensure interventions are indicated. Findings will be reviewed at the January 2019 QAPI Meeting.	

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F 657	Continued From page 21	F 657		

rising, between meals, at bedtime and during night when awake and willing to toilet, as well as with other interventions.

During observation on 10/24/18, 7:59 a.m., R30 was assisted to the bathroom by an unidentified nursing assistant. At 10:11 a.m., R30 stood up from being seated on her bed, walked out of her room and stated to an unidentified nursing assistant I have to find my purse. Nursing assistant asked R30 do you want to lay down or go up front and fold laundry. R30 stated I am looking for my laundry basket. Nursing assistant asked R30 if she wanted a drink, water, or Kool-Aid that was being passed out to residents. Nursing assistant gave R30 a drink of water and assisted R30 back out to the main living room area, seated R30 in a chair at the table and gave R30 a puzzle to work on.

R30's Guidelines for Nursing Note Documentation of Incidents, Quality Assurance Report Investigation of Incident and resident progress notes identified the following interventions were implemented:
On 6/27/18, 7:00 p.m. unwitnessed fall. Intervention: One to one.
On 6/28/18, 13:16 (1:16 p.m.) IDT team reviewed fall from last night. Will talk with activity staff about getting resident a sensory blanket.
On 7/11/18, 9:37 a.m. IDT reviewed two falls from 7/10/18. Staff provide 1:1 frequently or involve her in many activities.
On 8/30/18, 10:33 a.m., IDT review. Resident had self-transferred from bed and fell on the floor next to bed at 11a.m. (8/29/18). Will also see about having her listen to music while in her room.
On 8/31/18, 11:40 a.m., IDT team reviews fall from 8/30/18. Team has also discussed trying

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F 657	Continued From page 22 lavender spray/soap to help with the impulsivity in resident. R30's care plan lacked to include any of the interventions discussed after falls from list above. During interview on 10/25/18, at 1:33 p.m., the director of nursing (DON) confirmed R30's care plan with the interventions dated as above had not contained any new interventions which were not included in R30's comprehensive care plan to prevent falls. Policy Accident and Incident Investigation, dated 11/28/10, indicated Procedure: 13. Implement preventive measures as appropriate.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is	F 661		11/28/18

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F 661	Continued From page 23 developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a summary of the resident stay (recapitulation) for 1 of 1 resident (R53) reviewed for closed record review. Findings include: R53 closed medical record face sheet indicated the R53 was admitted following a stay at St. Mary's hospital for recurrent falls, decline in functional status and acute renal failure with tubular necrosis. R53 discharged from the facility on 8/8/18, to a REM home with home health therapy provided by Comfort Care. Review of the medical record revealed there was no evidence of the recapitulation of resident's stay document. On 10/25/18, at 9:20 a.m. the director of nursing (DON) stated they facility must have sent the original copy of the discharge summary that was completed with the resident, as the facility had not been able to find a copy of it. The DON stated she expected the facility to have a copy of the discharge summary in the resident's record. The Discharge/Transfer of the Resident policy dated 11/22/2010, directed staff to, "6. Complete a discharge summary and post discharge plan of	F 661	Deficiency with ID Prefix Tag R661 shall be corrected. Facility shall ensure a summary of the resident stay is filed in each closed record. The Discharge Summary for R53 was completed and reviewed with the resident and family upon discharge. The Nurse responsible sent the original with the resident upon discharge and did not make a copy. The Policy and Procedure for Discharge/Transfer of the Resident was reviewed and found accurate. The Clinical Nurse Managers have reviewed the Policy and Procedure and been reeducated on the proper procedure to ensure the Discharge Summary is in the closed record. The Administrator shall monitor this Plan of Correction for continued compliance through an audit of all discharges over the next three months. Findings will be reported at the January 2019 QAPI meeting.	

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F 661	Continued From page 24 care form. a. Include a list of medications with instructions in simple terms. Do not use medical terms or abbreviations. b. Include instructions for post discharge care and explain to the resident and/or representative. c. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care form. This included release of medications. d. Give copy of the form to the resident and/or representative or person(s) responsible for care. e. Place signed original of form in the medical record."	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a comprehensive non-pressure area for 1 of 1 resident (R21); the facility failed to monitor edema (swelling) for 2 of 2 residents (R7, R21) who had a diagnosis of congestive heart failure with treatments of compression and diuretic therapy; the facility failed to monitor diabetic management for 2 of 2 insulin dependent residents (R21, R15) reviewed for insulin control. Findings include:	F 684	Deficiency with ID Prefix Tag F684 shall be corrected. Facility shall comprehensively assess non-pressure areas, monitor edema for residents with Congestive Heart Failure with treatments of compression and diuretic therapy and monitor diabetic management for insulin dependent residents. R21's Non pressure skin concern was assessed on 10/24/2018 by CNM indicating a blister on left 3rd toe. Area measured and CNP notified. Provider	11/28/18

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F 684	Continued From page 25 R21's facility Diagnoses list dated 10/25/18, included diabetes type II, osteomyelitis (infection of the bone), and chronic kidney disease stage 5. R21's quarterly Minimum Data Set (MDS) an assessment dated 10/12/18, indicated R21 did not have cognitive impairment. The MDS also indicated R21 required extensive assist of one staff for bed mobility and personal hygiene, and limited assist from one staff for transfers. The MDS further indicated R21 was at risk for pressure ulcers and had a diabetic foot ulcer. R21's skin care plan dated 7/13/18, indicated R21 was at risk for skin break down and directed staff to document all new abnormal skin findings, report to nurse if skin is reddened, bruised, or had open areas, and to monitor skin with cares, showers, and as needed. The care plan also directed staff to follow facility protocol/regime for treating breaks in skin integrity/pressure ulcers. R21's skin/wound/pressure note dated 10/12/18, at 6:42 a.m. indicated during a wound dressing change a dark blister with no drainage was identified on the top of R21 left 3rd toe. The note indicated the blister was left open to air. R21's interdisciplinary team meeting note dated 10/12/18, at 11:18 a.m. indicated the team reviewed the blister that was found where staff had noted the area on the left 3rd toe appeared to be a blister, area was dark, and had not drainage or redness. The note indicated the blister would be assessed later that day. R21's skin/wound/pressure note dated 10/12/18, at 1:50 p.m. identified the pre-existing left diabetic	F 684	order entered on 10/24/2018 for treatment to area. R21 and R7's MAR's have been updated to document amount of edema and location. R21 new orders have been written for his Diabetic Management. All non pressure areas shall be assessed and reported appropriately. Edema shall be monitored per policy for residents with Congestive Heart Failure and treatments of compression and diuretic therapy and all residents with insulin dependent diabetes shall have their diabetes management monitored. Skin and Wound Policy and Procedure was reviewed with all licensed nurses. Education was provided through the Olmstead County Consortium on Edema and Congestive Heart Failure including monitoring and measuring. Policy and Procedure for edema monitoring for residents with Congestive Heart Failure has been updated. All nursing personnel have been reeducated on the importance of daily weights, when ordered, for residents with CHF and Edema. Policies and procedures for Diabetes Management have been reviewed and revised and all licensed nursing personnel have been reeducated. Emphasis was placed on ensuring documentation of interventions provided for hypoglycemic and hypoglycemic reactions. The DON/designee will monitor for continued compliance of this plan of correction through 1. audits of charts of residents with CHF and edema monitoring for proper monitoring documentation and	

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foot ulcer, however, lacked assessment of the left 3rd toe impaired skin integrity.

R21's skin/wound/pressure note dated 10/19/18, at 2:21 p.m. identified the left diabetic foot ulcer, however, lacked assessment of the left 3rd toe impaired skin integrity.

R21's record from 10/12/18 through 10/23/18, lacked evidence of a completed comprehensive assessment of the left 3rd toe, lacked evidence of ongoing monitoring, and lacked evidence of physician notification of the change in skin condition.

R21's skin/wound/pressure note dated 10/24/18, at 2:37 p.m. indicated the the blister on the left 3rd toe was assessed; area was noted with some dried blood, dark part of the blister measured 0.3 centimeters (cm), and dried gauze was placed on the area. The note further indicated the nurse practitioner would be updated and would have her look at the area on rounds on 10/25/18.

R21's new physician order note dated 10/24/18, at 3:07 p.m. included to clean blister on the left 3rd toe with normal saline and pat dry twice per day.

10/24/18 at 14:37 (2:37 p.m.)
Skin/wound/pressure area Note Text: Assessed blister to residents left 3rd toe at this time. Area was noted with some dried blood. This was cleansed with NS and dried. Dark part of blister measures 0.3 cm. Did place dry gauze over area. Will update CNP (certified nurse practitioner) at this time and have her look at area on rounds tomorrow. Resident denied any pain.

weights 3 times a week for a month, 2. Audits of Skin assessments documentation when a new non pressure area is identified 3 times a week for a month and 3. audits of diabetic residents charts to ensure proper documentation of interventions 3 times a week.

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F 684	Continued From page 27 During an observation on 10/23/18, at 8:34 a.m. R21 sat in recliner in his room. R21's legs had compression wraps on which allowed for visualization of his toes. An area on top the left 3rd toe was a pencil eraser sized raised fluid filled blister. The top of the blister and surrounding area had scant amounts of blood. R21 stated he was not aware of how he got it or why it was there. During an observation on 10/24/18, at 12:34 p.m. clinical manager registered nurse RN-C observed the area on R21's toe and stated the area looked like a blister. RN-C washed hands, donned gloves, used normal saline and gauze to clean the area on the toe, and left the area open to air. During an interview on 10/24/18, at 1:52 p.m. director of nursing (DON) verified R21's record lacked assessment and monitoring of R21's left 3rd toe blister. DON was not aware if the physician had been notified of the change. DON indicated an initial comprehensive wound assessment should have been completed with weekly assessments until resolution. The DON further expected the wound to be monitored for changes. During an interview on 10/24/18, at 2:52 p.m. clinical manager licensed practical nurse (LPN)-B indicated it was her responsibility to complete R21's wound assessments. LPN-B indicated she had not documented on the wound on 10/12/18, and should have completed weekly wound assessments. LPN-B further indicated the physician had not been notified of blister. During an interview on 10/25/18, certified nurse practitioner-A stated she had looked at R21's toe	F 684		

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F 684	Continued From page 28 and the blister was more than likely not caused from pressure, and was breakdown of the skin related to disease process. Facility policy Skin and Wounds dated 1/2018, included the following: 1. Body audits are done within 24 hours of admission and weekly 4. When a skin issue is noted, licensed staff fill out an incident report. Each clinical nurse manager is notified of the skin issue. 5. The area is measured and using nursing judgment, staff initiate appropriate treatment. MD is notified if needed. 6. CFNP reviews all new skin conditions with her rounds. 7. Interdisciplinary team (IDT) review new skin conditions at morning meeting. 8. All skin conditions are reviewed weekly during the IDT meeting. Progress notes from IDT area written weekly. CONGESTIVE HEART FAILURE MANAGEMENT: R7's diagnoses list dated 10/25/18, included diagnoses of chronic kidney disease stage 3, and dementia without behavioral disturbance. The list lacked identification of the diagnoses of congestive heart failure (CHF). R7's significant change Minimum Data Set (MDS) an assessment dated 8/1/18, indicated R7 did not have cognitive impairment and used diuretic medication 5 of 7 days during the assessment period. The MDS lacked identification of the diagnosis of (CHF). R7's physician orders dated 10/25/18, included:	F 684		

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F 684	Continued From page 29 Compression stockings on during the day and off at night for edema (start date 7/19/18) Daily weights every morning prior to breakfast (start date 7/13/18) Hydrochlorothiazide (diuretic medication); with indication for blood pressure (start date 10/9/18) R7's nutritional care plan dated 8/3/18, directed staff to monitor weight and monitor skin daily for any redness, pressure areas, or circulatory changes. The care plan lacked identification of diagnosis of CHF, goals, and interventions for management. R7's physician note dated 10/8/18, indicated R7 had a history of congestive heart failure and weight was increased to 196.4 pounds (lb.), which was up significantly since earlier this year (was 180 lbs.). The physician note indicated R7 had been refusing Lasix (diuretic medication), because of frequent trips to the bathroom and a gentler diuretic would be started (Hydrochlorothiazide). The note indicated R7's lower extremities had 1-2+ pitting edema. R7's physician note dated 10/18/18, indicated the weights had stabilized since switching from Lasix to Hydrochlorothiazide. However, if symptoms of heart failure exacerbation in future, obtain chest x-ray to evaluate for pulmonary vascular congestion or infiltrate and consider switch to chlorthalidone if weight over 195. Physician visit also indicated R7 had trace pitting edema to the mid shins bilaterally. R7's record lacked evidence of monitoring of edema in lower extremities. R7's weights were reviewed from 9/1/18 through 10/23/18, the record revealed daily weights were not	F 684		

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F 684	Continued From page 30 documented on 9/2, 9/10, 9/13, 9/24, 10/4, 10/14 and 10/15/18. During an observation on 10/23/18, at 8:52 a.m. R7 sat in a chair in his room, had compression stockings on his lower extremities, and both legs were observed to be edematous. During an interview on 10/24/18, at 3:00 p.m. case manager licensed practical nurse (LPN)-B confirmed R7's record lacked routine edema monitoring and evaluation. LPN-B indicated the facility would notify the physician if there was a weight gain, if R7 became short of breath, and/or became symptomatic of congestive heart failure. LPN-B also confirmed R7's lacked evidence lung sounds were monitored. During an interview on 10/24/18, at 1:52 a.m. director of nursing (DON) stated in conjunction with weight monitoring, edema should also be monitored and evaluated to ensure the compression treatment is appropriate and/or effective. DON further indicated edema monitoring and evaluation should be documented which included extent and location of edema. R21's facility Diagnoses list dated 10/25/18, included diagnoses of mild cognitive impairment, chronic renal disease stage 5, anxiety disorder, and diabetes type II. The diagnosis list lacked diagnosis of congestive heart failure (CHF). R21's quarterly Minimum Data Set (MDS) dated 10/12/18, indicated R21 did not have cognitive impairment. The MDS also indicated R21 required extensive assist of one staff for bed mobility, dressing, and personal hygiene. The MDS further indicated R21 had a diabetic foot	F 684		

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ulcer, and used diuretic medications every day during the assessment period. The MDS lacked identification R21 had a diagnosis of CHF.

R21's physician orders dated 10/25/18, included the following:
-Wrap legs in low stretch wraps daily two time a day for edema on during the day off at bedtime (start date 7/19/18)
-Torsemide (diuretic medication) 40 milligrams (mg) two time a day for fluid (start date 10/4/18)
-Check bilateral lower extremity edema daily for fluid. Do with dressing change. Document location and amount of edema. This was added to the orders on 10/24/18, during the survey process.

R21's care plan indicated R21 was at risk for complications related hypertension dated 7/13/18, included and directed staff to give medications and complete labs as ordered, as well as monitor for edema. R21's nutrition care plan dated 10/18/18, indicated R21 was on a therapeutic diet, was not compliant; that care plan included and directed staff to monitor for and report to physician any circulatory changes.

R21's weight record from 10/1/18 through 10/23/18 indicated R21 had gained almost 9 pounds (lbs). Although R21's record reflected the weight monitoring and adjustments made to diuretic medication therapy, the record lacked evidence of monitoring/evaluation or improvement of edema as directed by the care plan.
10/23/2018 09:36 339 Lbs
10/22/2018 09:00 340 Lbs
10/18/2018 09:00 336.8 Lbs
10/15/2018 09:00 335.6 Lbs

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F 684	Continued From page 32 10/12/2018 07:07 332.6 Lbs 10/09/2018 13:48 325.2 Lbs 10/06/2018 11:00 332.8 Lbs 10/04/2018 10:00 330.6 Lbs 10/01/2018 07:22 330.2 Lbs During an observation on 10/22/18, at 8:34 a.m. R21 sat in recliner chair with his legs/feet in the dependent position (down). R21 had low compression wraps on both legs; both legs were edematous as well as his toes that were visible as the compression wrap started mid foot. R21 stated, he was not on a fluid restriction, has had more edema in lower extremities, however, the diuretic could not be increased because of his kidney function. R21 indicated staff did not measure the amount of edema in his legs by pushing on the skin. During an observation on 10/23/18, at 8:29 a.m. R21 sat in recliner with legs elevated. Both legs continue to be very edematous. R21 had compression wraps on only to the left foot. Both legs had areas of bumpy raised skin with no discoloration; R21 stated he was not aware of the areas on his legs and didn't know what that was caused from. During an observation on 10/23/18, at 2:38 p.m. R21 sat in his recliner with his feet slightly elevated; compression wraps were on both legs. During an interview on 10/24/18, at 7:29 a.m. registered dietician (RD) stated she expected nursing to monitor and evaluate edema and fluid intake as a means to help determine if weight gain was related to nutritional intake or fluid intake and report the nursing assessment to dietary. RD stated R21 has had an 18.5% weight	F 684		

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F 684	Continued From page 33 increase in the last 3 months. During an interview on 10/24/18, at 10:19 a.m. with clinical manager licensed practical nurse (LPN)-B indicated staff looked at R21's edema when the compression wraps were applied. LPN stated the facility was not specifically monitoring or evaluating edema and/or measurements. LPN further indicated edema may be mentioned in a Medicare progress note, however, verified the record lacked ongoing monitoring and evaluation. During an interview and observation on 10/24/18, at 12:34 a.m. clinical manager registered nurse (RN)-C indicated when a resident was on a diuretic medication, daily weights were obtained to monitor edema. RN-C stated R21's left foot had some puffy and firm edema and the ankle aspects had 2+ pitting edema. RN-C also indicated from the knee to just above the ankle, R21 had very firm edema with no pitting. RN-C then stated R21's right foot had 2+ edema throughout and had firm edema from ankle to knee with very taught edema around the knees. R21 stated his right hand also was puffy and felt taught when he made a fist. During an interview on 10/24/18, at 1:52 a.m. director of nursing (DON) stated in conjunction with weight monitoring, edema should also be monitored and evaluated to ensure the compression treatment is appropriate and/or effective. DON further indicated edema monitoring and evaluation should be documented which included extent and location of edema. Facility policy Weight Assessment and Intervention dated 2/24/15, included: 3) If the resident has a diagnosis of congestive heart	F 684		

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failure or any other cardiac diagnosis requiring diuretic medications, the clinical nurse manager, of the assigned wing, will follow-up with the Medical Professional for further direction and assistance with weight management plan.

Monitoring and evaluation of interventions for edema management was requested and not received.

DIABETIC MONITORING:
R21's facility diagnoses list dated 10/25/18, included diagnosis of diabetes type II with foot ulcer and diabetic nephropathy, chronic kidney disease stage 5, and mild cognitive impairment.

R21's quarterly Minimum Data Set an assessment dated 10/12/18, indicated R21 did not have cognitive impairment, had a diagnosis of diabetes, and required insulin every day during the assessment period.

R21's physician orders dated 10/25/18, included the following:
-Blood sugar checks four times a day before meals and at bedtime (start date 8/21/18)
-May use standing orders (start date 7/13/18)
-Insulin Aspart Pen-injector 15 units subcutaneously three time a day with meals (start date 8/21/18)
-Insulin NPH (Human) (Isophane) suspension Pen Injection 100 units/milliliter (ml), inject 20 units subcutaneously one time a day with the evening meal (start date 10/3/18)
-Insulin NPH (Human) (Isophane) suspension pen injection 100/unity/ml, inject 50 units subcutaneously one time a day (start date 10/3/18)

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F 684	Continued From page 35 R21's physician's Post-Acute and Long Term Care Standing Orders signed and dated 7/13/18. The standing orders direct nurses to notify the provider if there are 2 consecutive glucose readings of less than 70 or greater than 400; however, R15's record fails to show that an additional glucose test was done after any of the abnormal tests to determine if the provider should be notified; furthermore, the record does not show any action taken to correct the noted hypoglycemia. R21's diabetic care plan dated 10/18/18, indicated R21 was at risk for endocrine complications related to diagnosis of diabetes, required a therapeutic diet, and was non-compliant with diet order. The care plan lacked identification of goal range for R21's blood sugars. The care plan directed the following: diet as ordered, encourage diet compliance, medication and lab work as ordered-report abnormal results promptly to MD (medical doctor), and monitor blood sugars as ordered by MD. The care plan further directed staff to monitor resident for thirst, excessive appetite or voiding perspiring, change in level of consciousness or mood, and report to MD immediately. During an interview on 10/22/18, at 1:59 a.m. R21 stated a history of having low blood sugars in the morning; sometimes in the 50's. R21 indicated when he first woke up in the morning he couldn't readily identify signs and symptoms of hypoglycemia (low blood sugar). R21 stated once he was up, he could only tell if his blood sugar was low was when he could see blood behind his left pupil which typically presented when his blood	F 684		

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F 684	Continued From page 36 sugars were below 100. R21 stated that when his blood sugars were in the 50's nurses would give him one of his cookies or give him 2 glasses of orange juice. R21's record and blood sugar recordings were reviewed from 9/1/18 through 10/23/18. The record identified multiple blood sugar recordings below 100 when R21 stated he started to experience symptoms; as well as several recordings below 70. The record lacked documentation of signs and symptoms of hypoglycemia, interventions that were utilized, and outcome of the outcome of the interventions which included rechecks of the blood sugars to ensure safe ranges. -On 10/21/18, at 9:39 a.m. blood sugar (BS) was 74, the record indicated the BS was rechecked at 9:41 a.m. and was the same reading. The record did not identify if the blood sugar was rechecked or if interventions were used. -On 10/17/18, at 8:07 a.m. and at 9:14 a.m. BS was 86, progress notes (PN) did not identify signs or symptoms or intervention. -On 10/16/18, at 6:40 a.m. BS was 65, PN indicated R21 was easily awaken and a chocolate chip cookie was given. The record indicated BS was rechecked at 10:21 a.m. was the same at 65, with no further documentation. -On 10/15/18, at 6:43 a.m. BS was 83, PN did not identify signs/symptoms or interventions. -10/10/18, at 8:10 a.m. BS was 170; At 9:08 a.m. BS was 73; PN did not identify why R21's blood sugar had dropped significantly during that time. -10/9/18, at 6:48 a.m., 10:37 a.m., and 10:38 a.m. BSs were recorded as 83; PN did not identify any further information. -On 10/8/18, at 6:53 a.m., and at 9:54 a.m. BS's were recorded as 93; PN did not identify any	F 684		

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F 684	Continued From page 37 further information. -On 10/2/18, at 4:21 p.m. BS was recorded as 91; PN did not identify any further information. -On 10/2/18, at 6:37 a.m. and at 9:10 a.m. BS were at 69; PN did not include interventions. -On 9/30/18, at 8:37 a.m. and at 9:14 a.m. BS were 72; PN did not include interventions or any other information. -On 9/29/18, at 6:33 a.m. and at 9:18 a.m. BS were 60; PN did not include interventions other than insulin NPH was given after breakfast. -On 9/28/18, at 6:37 a.m. and at 9:18 a.m. BS were 76; PN did not include any other information. -On 9/26/18, at 6:54 a.m. and at 9:00 a.m. BS was 60; PN did not include interventions. -On 9/19/18, at 8:59 p.m. and 10:00 p.m. BS was 75; PN indicated Insulin NPH was given along with a bed time snack. PN did not include a recheck after NP insulin administered. -On 9/19/18, at 6:51 a.m. and at 9:05 a.m. BS was 61; PN did not include interventions. On 9/17/18, at 9:48 a.m. and at 9:49 a.m. BS was 63; PN did not include interventions. -On 9/15/18, at 6:33 a.m. BS was 62 and at 9:37 a.m. BS remained the same at 62: PN did not include interventions -On 9/14/18, at 9:38 a.m. BS was 81; PN notes did not include any further information. -On 9/11/18, at 8:54 a.m. and at 8:55 a.m. BS was 68; PN did not include interventions utilized. -On 9/5/18 at 9:28 a.m. and at 9:29 a.m. BS was 73; RN did not include signs/symptoms or interventions utilized. -On 9/1/18, at 6:54 a.m. and at 8:41 a.m. BS was 87; PN did not include signs/symptoms or interventions utilized. During an interview on 10/24/18, at 10:19 a.m.	F 684		

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with clinical manager licensed practical nurse (LPN)-B confirmed lack of documentation of completion of rechecked blood sugars when out of safe range, as well as, documentation of signs/symptoms, interventions, and response to the interventions. LPN-B indicated R21 had not shown any signs or symptoms in the morning of hypoglycemia. LPN-B stated if the blood sugars were below 70 orange juice was administered if the resident was responsive and alert. LPN-B stated blood sugars were below 70, the blood sugar needed to be rechecked after 30 minutes. LPN-B further indicated the long acting NPH insulin would be administered, however the short acting would not be given until the resident was eating breakfast. LPN-B then stated if blood sugars were not in normal ranges then documentation was supposed to include what the blood sugar was, signs and symptoms of hypo/hyperglycemia, interventions used which included the blood sugar rechecks. LPN-B indicated the physician was notified if there were two consecutive blood sugar readings under 70.

During an interview on 10/24/18, at 11:33 a.m. LPN-A indicated if R21 felt his blood sugar was low he was given a glass of juice. LPN-A indicated R21 didn't feel hypoglycemic symptoms until he was in the 70's. LPN-A stated she checked R21's morning blood sugar between 7:00-7:30 a.m., and has historically had blood sugars in the 50's. LPN-A further stated when R21's blood sugars were in the 50's she would give him a glass of orange juice, but would wait an hour or so because R21 got up for breakfast around 9:00 a.m.. LPN-A stated documentation for diabetic monitoring should include what the blood sugar was, recheck results, signs/symptoms, and interventions that were

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used.

During an interview at 10/24/18, at 11:39 a.m. trained medication assistant (TMA)-A, indicated she obtained blood sugar readings. TMA-A stated depending on how low the blood sugar was and signs and symptoms the resident was exhibiting dictated what her immediate response was. TMA-A stated if the resident's blood sugar was low, but they were alert, she would immediately report to the nurse, however if the residents blood sugar exhibiting symptoms but was still able to swallow, she would give some orange juice, and put on the call light to get the nurse. TMA-A indicated it was the nurse's responsibility to complete documentation for hypo/hyperglycemia.

During an interview on 10/24/18, at 11:41 a.m. registered nurse (RN)-C stated for alert residents with low blood sugars, they were given orange juice. RN-C stated the blood sugar would then be rechecked after 15-20 minutes. RN-C further stated documentation should include results of initial and subsequent blood sugar results were, signs/symptoms of hypoglycemia, interventions and response to the interventions.

During an interview 10/24/18, at 1:52 p.m. director of nursing (DON) reviewed and verified R21's record lacked consistent documentation blood sugar rechecks when necessary, signs/symptoms, interventions, and response to interventions. DON indicated an expectation of complete documentation. DON indicated if a blood sugar was low, the standard was to recheck blood sugar every 15 minutes until the blood sugar was 100 or higher.

Facility policy Diabetes Mellitus Guidelines dated

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F 684	Continued From page 40 11/18/10, did not identify requirements for documentation. The policy included the following: 1) assist the resident to establish a balance between diet, exercise, and insulin 2) restore carbohydrate utilization, correct electrolyte imbalance and prevent ketoacidosis 3) quickly restore normal cerebral function and prevent hyperglycemia or hypoglycemia 4) recognize, treat, and prevent complications commonly associated with diabetes. The policy directed staff of the following -If finger stick glucose is less than 70 and asymptomatic, give glucose/carbohydrates orally -If finger patient becomes symptomatic and glucose is below 70 give glucose/carbohydrate and protein orally. Notify provider. Continue to monitor finger stick glucose and treat every 15 minutes until glucose is over 100 -Notify provider if 2 consecutive glucose readings below 70 and/or over 400. R15's face sheet included a diagnosis of diabetes mellitus type two and physician orders instruct the nursing staff to perform blood glucose checks before meals and at bedtime because of this diagnosis. The physician orders also indicate that R15 receives Lantus/glargine, a long lasting insulin and Novolog/Aspart, a rapid acting, short lasting insulin. Both of these medications are given to assist in maintaining blood glucose levels within a safe and normal range for the diabetic patient. R15's medical record showed the following incidents of hyperglycemia (high blood glucose) greater than 400 mg/dL (milligrams per deciliter) that conversely fail to show any nursing response, including reassessment or a documented report to R15's physician/medical provider:	F 684		

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F 684	Continued From page 41 10/10/2018 19:18 492 mg/dL 10/10/2018 11:18 433 mg/dL 09/08/2018 11:04 422 mg/dL 08/29/2018 16:17 428 mg/dL 08/05/2018 19:50 486 mg/dL R15's medical record showed the following incidents of hypoglycemia (low blood glucose) less than 70 mg/dL that conversely fail to show any nursing response, including reassessment or a documented report to R15's physician/medical provider: 10/05/2018 16:21 67 mg/dL 09/24/2018 16:49 62 mg/dL 09/08/2018 16:36 66 mg/dL 09/04/2018 16:21 59 mg/dL R15's physician's Post-Acute and Long Term Care Standing Orders signed and dated 5/26/17, direct nurses to provide glucose/carbohydrates orally if 2 consecutive glucose readings are less than 70 and the patient is without symptoms or if symptoms are present to give glucose/carbohydrate and protein and notify the provider. The standing orders direct nurses to notify the provider if there are 2 consecutive glucose readings of less than 70 or greater than 400; however, R15's record fails to show that an additional glucose test was done after any of the abnormal tests to determine if the provider should be notified; furthermore, the record does not show any action taken to correct the noted hypoglycemia. According to an interview on 10/25/18, at 9:48 a.m. about expectations of nursing assessment and interventions upon abnormal findings, the director of nursing (DON) stated that the standard of nursing practice would be to do further	F 684		

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F 684	Continued From page 42 assessment to determine the problem and take action. A policy was requested but none provided.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for root cause analysis related to falls and implement interventions to minimize the risk for injury for 2 of 4 residents (R30 and R15) reviewed for accidents. This resulted in actual harm for R30. Findings include: R30's quarterly Minimum Data Set (MDS) an assessment, dated 9/26/18, indicated R30 was admitted to the facility on 6/22/18, had severe cognitive impairment, required limited assist of one person for transfers and ambulation, had falls since admission, two with no injury and two with injury. R30's current care plan indicated Focus: resident is at risk for falls. Safety Checks due to resident history of frequent falls. Interventions dated	F 689	Deficiency with ID Prefix Tag F689 shall be corrected. Facility shall comprehensively assess for root cause analysis related to falls and implement interventions to minimize risk of injury. R30's care plan has been updated to include interventions based upon root cause analysis of previous falls. All resident falls shall have a root cause analysis done at the time of falls with interventions identified and implemented. The Falls Policy has been reviewed and updated to include a review of a fall at the time it happens with a root cause analysis completed and intervention to be implemented. IDT shall review all falls, the root cause analysis completed and interventions put in place for appropriateness and/or further interventions needed. The Fall Scene Investigation form has been revised and	11/28/18

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F 689	Continued From page 43 6/22/18, included Faber fall risk evaluation to be completed upon admission, after a fall, with a significant change, quarterly and as needed (PRN). Instruct/remind resident to use call light when needing assistance. Monitor resident for steadiness when ambulating. Staff to assure resident receives assistance when needed. Interventions dated 8/29/18, included provide distraction such as folding towels. Resident does not use wheelchair. Use walker at all times. While resident is sitting/lying, walker is to be out of walking path to prevent resident bumping into it and tripping/falling as resident does have poor vision. Resident wears hip protectors. When resident becomes restless, offer to go for a walk with assist of 1, front wheel walker (FWW), and gait belt. Interventions added 9/14/18, indicted offer distractions when resident becomes impulsive, to include folding towels/clothes, conversing, going for a walk, participating in the day's activities, having a snack, etc. Cue/assist to toilet upon rising, between meals, at bedtime and during night when awake and willing to toilet, as well as with other interventions. R30's Faber Fall Risk Data, dated 9/26/18, indicated significant risk for falls. During observation on 10/24/18, 7:59 a.m., R30 was assisted to the bathroom by an unidentified nursing assistant. At 10:11 a.m., R30 was seated in a chair at a table in the main living room area. R30 stood up and an unidentified therapy person asked R30 if she needed to use the bathroom, R30 replied "Yes." R30 was ambulated with a walker and gait belt to her room and an unidentified nursing assistant further assisted R30 to toilet. Once in her room R30 stated I want to sit on my bed for a minute. R30 stood up from	F 689	updated. All nursing personnel have received education on root cause analysis and identifying interventions to minimize the risk of injury from further falls. All Falls shall be logged on an individual resident fall log to assist in tracking and trending time, location, activity prior to fall and safety devices in use. The Director of Nursing shall monitor continued compliance with this plan of correction by auditing all falls for one month to ensure a root cause has been identified and interventions have been put in place. Findings shall be reviewed at the January 2019 QAPI meeting.	

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F 689	Continued From page 44 being seated on her bed, walked out of her room and stated to the nursing assistant I have to find my purse. Nursing assistant asked R30 do you want to lay down or go up front and fold laundry. R30 stated I am looking for my laundry basket. Nursing assistant asked R30 if she wanted a drink of water or koolaid that was being passed out to residents. Nursing assistant gave R30 a drink of water and assisted R30 back out to the main living room area, seated R30 in a chair at the table and gave R30 a puzzle to work on. R30 had not been toileted while in her room but was moved from her bed to the living room area. R30's Guidelines for Nursing Note Documentation of Incidents, Quality Assurance Report Investigation of Incident, physician progress notes, resident progress notes and therapy notes included the following: -6/22/18, at 22:50 (10:50 p.m.) admission, resident is alert to self, very forgetful and impulsive. Oblivious to her own safety and limitations. Keeps standing and trying to ambulate independently and is very unsteady. -6/23/18, at 0830 (8:30 a.m.), self transferred from wheelchair (w/c) in hallway, lost balance and fell next to w/c hitting her head on the floor. Resident wearing neck brace when fall occurred. Root cause of fall: resident has history of falls related to confusion and dementia. Initial intervention to prevent further falls: use of wheelchair for transportation. However, R30 was already utilizing a wheelchair. -6/23/18, at 5:10 p.m., sitting in w/c at the table in day room, from across room staff saw resident push away from the table to stand, turn slightly and crumple to the ground, landing on butt. No root cause was documented and no new interventions were implemented.	F 689		

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F 689	Continued From page 45 -6/23/18, at 18:15 (6:15 p.m.), unobserved. Second fall of the evening. Found sitting on bottom next to wheelchair. Denied hitting head, stated right buttock was sore. No injuries observed. No root cause was documented and no new interventions were implemented. -6/24/18, at 9:30 a.m. resident slipped out of w/c landing on floor twice. Slipped and landed on elbows and knees with forehead on floor first time at 0900 (9:00 a.m.), slipped under table and found sitting on her bottom second time at 0930 (9:30 a.m.). Root cause: weakness, confusion and leaning over arms of w/c. Interventions: close monitoring and 15 minute checks. -6/24/18, at 12:30 p.m., fell in dayroom. No root cause was documented and no new interventions were implemented. -6/25/18, IDT note at 11:52 a.m. Team reviewed falls from the weekend. Resident has been assist of two with transfers since admission. Her room is located near the nurses desk. She will be evaluated by therapy today. Therapy will also be getting her a self-locking wheelchair. Will continue to monitor resident frequently. The note lacked documentation by the IDT for root cause analysis for the falls occurring on 6/23/18 and 6/24/18, to determine appropriate interventions. -6/25/18, at 14:45 (2:45 p.m.) resident seen resting in bed at 2:15 p.m. and as staff passed her room at 2:30 p.m. she was noted to be laying on the floor next to her bed. No root cause was documented and no new interventions were implemented. -6/26/18, at 2:45 p.m. IDT team reviewed fall from yesterday afternoon. Resident is participating in PT (physical therapy)/OT (occupational therapy), they are working on getting her a self -locking wheelchair. There was no documented root cause analysis of the fall to determine appropriate	F 689		

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F 689	Continued From page 46 interventions to implement. R30's physician progress note, dated 6/26/18, for admission to the facility indicated diagnosis of dementia, recurrent mechanical falls, recent C7 lateral mass fracture requiring C-collar. Patient admitted Friday and no therapy until Monday. Patient is very impulsive and regularly transfers, hence fell seven times over the weekend. IDT (interdisciplinary team) addressed first thing Monday morning. Assessment/Plan: staff will review orthostatic BP/P (blood pressure/pulse) in three days. IDT continues to review modalities with therapy to minimize falls. Minimal medications. Labs noncontributory. Current co-morbidities, ADL (activities of daily living) need/level of debility require skilled care/therapy. -6/27/18, 7:00 p.m. unwitnessed fall. Resident toileted at about 6:30 p.m. and then went out to sit in w/c next to the nurses cart. As this nurse entered another residents room to give a medication this resident stood up and tumbled forward onto the floor. Found on her hands and knees and as this writer called for assist she stood up on her own and started to fall backwards as this writer caught her and guided her to the chair. Root cause: confusion and residents inability to know limitations and safety. Intervention: One to one. -6/28/18, at 13:16 (1:16 p.m.) IDT team reviewed fall from last night. Resident is very impulsive and had been doing one to one time throughout the night with a few staff. Resident is participating in PT/OT for strengthening. Will talk with activity staff about getting resident a sensory blanket. Will also obtain hip protectors for resident. Therapy is also looking into getting a weighted blanket for resident to try out. Continuing to monitor resident and provide assistance frequently. However, the note lacked to include	F 689		

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F 689	Continued From page 47 documentation of root cause analysis to determine an appropriate intervention to implement. R30's care plan lacked to include the interventions of sensory blanket and weighted blanket. -6/29/18 - OT therapy note indicated the patient's new self-locking wheelchair arrived. - 7/2/18, at 9:30 a.m. aide assisted resident to table to organize cards and aide locked breaks. Aide went back to independent DR (dining room), turned around and saw resident standing, stumbled and tripped on her own feet, landing on her right side. No root cause was documented and no new interventions were implemented. -7/3/18, at 10:14 a.m., IDT team reviewed fall at 9:30 a.m. Resident has a self- locking wheelchair and hip protectors. Staff involve resident is many activities to keep her preoccupied. She will play with cards or fold towels. Resident does have very poor vision as well. Will continue to monitor resident. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -7/8/18, at 10:35 a.m., self transferred, lost balance while standing up, stumbled over w/c foot pedals and fell to floor landing on her right shoulder and hip. Intervention: removed w/c foot pedals. There was no documented root cause analysis. -7/9/18, at 10:38 a.m., IDT reviewed fall from 7/8/18. Resident is working with PT/OT. She has a self-locking wheelchair. She does not know to wait for help and will do things on impulse. Resident does have dementia. She also wears hip protectors. Staff encourage her to participate in activities or play cards, fold towels, color, etc. Resident does have poor vision as well. Continuing to monitor resident. There was no documented root cause analysis of the fall to	F 689		

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F 689	Continued From page 48 determine appropriate interventions to implement. -7/9/18, at 3:00 p.m., resident sitting at table in day room with towels, magazines and markers. Resident left unattended for few minutes and she stood up and walked into day room. Staff came around the corner to see her stumble and crumple to the floor. Root cause: inability to be aware of own safety limitations. Interventions: one to one. There was no documented IDT review of the fall for 7/9/18, at 3:00 p.m., to determine root cause analysis and an appropriate intervention to reduce falls from recurring. - 7/10/18, at 2:15 p.m. Resident was sitting at table in day room with magazines and playing cards. Nurses were in report for shift change. Resident got up independent and began to ambulate. Stumbled on her own feet and fell to the floor. Witnessed by CNA (certified nursing assistant) who was unable to reach resident fast enough to prevent fall. Root cause: confusion and forgetfulness. Does not realize her own limitations. Intervention: one to one. There was no documented root cause analysis. - 7/10/18, at 6:30 p.m. Activity staff were doing a 1:1 with resident. Another resident asked the activity aide a question and when she turned away to answer the person R30 got up, started to walk and fell hitting her head. The fall was witnessed by the unit secretary. Resident hit the right side of her head near the temple area on the stand. Root cause: very impulsive, forgetful, does not understand or remember her limitations. Intervention: one to one. There was no documented root cause analysis. -7/11/18, at 9:37 a.m. IDT reviewed two falls from 7/10/18. Resident does become impulsive and has a short attention span. She does have dementia and does not understand to ask for help	F 689		

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F 689	Continued From page 49 when needing to ambulate/transfer. Staff provide 1:1 frequently or involve her in many activities. She has a self-locking wheelchair and hip protectors, and she is working with PT/OT. Therapy is working on getting her a weighted blanket to possibly help with the impulsiveness (continues to be mentioned from previous fall). Will continue to monitor resident. R30's care plan lacked to include staff provide 1:1 frequently. There was no documented root cause analysis of the falls on 7/10/18, to determine appropriate interventions to implement. -8/3/18, IDT team. Resident participates in PT/OT. She is doing well. She is assist of one with FWW to all destinations. Resident does not use a wheelchair. - 8/11/18, at 8:15 p.m. Resident ambulating in the hallway looking for her sister. Apparently stumbled and fell to floor, unwitnessed. Root cause: oblivious to own safety and limitations. There was no review for root cause analysis to determine an appropriate intervention. There was no documented IDT review of the fall for 8/11/18, at 8:15 p.m., to determine root cause analysis and an appropriate intervention to reduce falls from recurring. -8/13/18 room change to room 110 to be right next to the nurses station. -8/14/18, at 10:30 a.m. Resident found on floor next to table in main lobby. Root cause: confusion. Interventions: provide distractions, activities and one to one. There was no review for root cause analysis to determine if the interventions implemented were appropriate. There was no documented IDT review of the fall for 8/14/18, at 10:30 a.m., to determine root cause analysis and an appropriate intervention to reduce falls from recurring. -8/29/18, at 4:40 a.m. Resident was found lying	F 689		

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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 689	Continued From page 50 on the floor in room 118. Resident obtained a large, deep laceration on the left forehead measuring 3 cm (centimeters) long. Resident was up and down all night. She had been toileted every hour. Both aides working the hall were helping other residents when her fall happened. Root cause: wandering unattended with an unsteady gait. Intervention: needs to be monitored more closely. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -8/29/18 at 4:06 p.m. IDT team review. Resident was wandering in the halls and she fell and hit her head. Resident is assist of one for all transfers and ambulation with gait belt and FWW. Resident wears hip protectors. She has very poor vision and dementia. She does not remember to ask for assistance. Resident is also impulsive. Her room is located next to the nurses desk. Staff encourage resident to participate in different activities to include folding towels. Redirection is not always effective when resident becomes impulsive. No changes made at this time. There was no documented root cause analysis to determine why R30 was wandering the halls and an appropriate intervention to reduce recurrence of falls. -8/29/18, at 11:00 a.m. Resident self transferred from bed and fell on floor next to bed. There was no review for root cause analysis to determine an appropriate intervention. -8/30/18, at 10:33 a.m., IDT review. Resident had self-transferred from bed and fell on the floor next to bed at 11a.m. (8/29/18). Resident is located across from the nurses desk. She is encouraged to participate in many activities, and likes to fold towels. Staff provide 1:1 at times. She wears hip protectors and does not use a w/c as this was a safety issue. Resident is walked to all	F 689		

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F 689	Continued From page 51 destinations with FWW and gait belt and assist of one. Therapy will see about using the weighted blanket when resident is taking naps or when sleeping at night (repeat of weighted blanket use). Will offer warm blankets. Staff have tried picture books/magazine with her but due to resident's poor vision, these do not interest here. Staff will try to provide colored towels/socks/clothing for resident rather than just the white towels for folding. Will also see about having her listen to music while in her room. However, there was no root cause analysis of the fall to determine if the interventions implemented were appropriate. - 8/30/18, at 11:30 a.m. Resident was sitting in the assisted dining room. She was seen attempting to stand up and turn to leave the table. She lost her balance and fell to her hands and knees then she rolled over onto her butt. Root cause attempting to self transfer, lost balance and fell. Interventions: staff sat with resident at lunch to provide one to one. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -8/30/18 at 2:45 p.m. Resident found sitting in her room by bathroom door. Root cause: confused mental status. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -8/31/18, at 11:40 a.m., IDT team reviews fall from 8/30/18. Talked with therapy and they will be trying the weighted blanket today (repeat of weighted blanket). Resident will also be put on a walking program. Will try having resident listen to music while she is in her room (repeat of music in room). Will talk with family about what kind of music she likes. Resident will also be placed on every 15 minute checks. Team has also discussed trying lavender spray/soap to help with	F 689		

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F 689	Continued From page 52	F 689		

the impulsivity in resident. However, there was no root cause analysis of the fall to determine if the interventions implemented were appropriate.
-9/16/18, at 10:30 a.m. Resident self transferred and fell. She was walking between furniture, lost her balance grabbed/held onto chair located on both sides of her and lowered self to floor. Root cause: confusion. Intervention: provide distraction and activities.
-9/17/18, at 9:57 a.m. IDT review fall on 9/16/18. Interventions were documented as reviewed with no changes at this time. There was no documented root cause analysis of the fall to determine appropriate interventions to implement.

During interview on 10/25/18, at 10:55 a.m., Registered nurse (RN)-B stated R30's fall interventions were having a room located near the nurse station, hip protectors, assist of one walking, get involved activities as folding clothes, go for walks, have snack or cup of coffee, chocolate milk. RN-B stated regarding the weighted blanket, I know R30 used the weighted blanket, but I have not herd how the weighted blanket worked out.

During interview on 10/25/18, at 11:07 a.m., nursing assistant (NA)-G stated R30's fall interventions were try to make sure safe, walker in front of her, keep occupied with laundry, puzzles, coloring. Toilet every two hours and make sure her bed is at the lower level.

During interview on 10/25/18, at 11:09 a.m. NA-H stated R30's fall interventions were keep R30 in the front busy folding laundry, puzzles, take for walk, toilet, sometimes will nap and color. R30 likes to sit and have coffee and cookies. I know activity staff will spend one on one time with her

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F 689	Continued From page 53 too. During interview on 10/25/18, at 1:33 p.m., the director of nursing (DON) confirmed R30's care plan and the date interventions were implemented. The DON confirmed the falls for 6/23/18, and stated there was no documentation for root cause analysis of the falls and no new interventions implemented. The DON stated for the falls on 6/24/18, at 9:00 a.m. and 9:30 a.m. there was no documented root cause for each fall to determine an intervention. DON stated for the IDT note dated 6/25/18, had no documented root cause analysis of the falls occurring on 6/23/18, and 6/24/18, to determine appropriate interventions to implement. The DON stated for the IDT review on 6/28/18, the root cause of the fall on 6/27/18 was impulsiveness. DON confirmed the sensory blanket and weighted blanket were not on R30's care plan. DON and RN-B (who joined during the interview) stated they could not answer if the sensory blanket and the weighted blanket was implemented by therapy or not. The administrator (who joined during the interview) stated she did not see the sensory blanket documented in an activity note. Don confirmed there was no documented root cause and intervention implemented for the fall on 7/2/18, at 9:30 a.m. The DON confirmed the IDT team did not review the falls on 7/9/18, at 3:00 p.m. and on 8/14/18, at 10:30 a.m. to determine root cause analysis and an appropriate intervention to reduce falls from recurring. The DON stated for the fall on 8/29/18, at 4:40 a.m., there was no documentation by staff to show what other interventions were tried with R30 during the night besides toileting. The DON confirmed the intervention of have R30 listen to music while in room was not documented in	F 689		

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F 689	Continued From page 54 R30's care plan. DON confirmed use of lavender spray/soap was not on R30's care plan. Don stated the root cause of the falls on 8/30/18 was self-transferring. DON confirmed R30's care plan lacked to include staff provide 1:1 frequently or involve her in many activities. During the interview with the DON and RN-B, the DON and RN-B confirmed the use of a weighted blanket form therapy continued to be mentioned as an intervention, but there was no documentation on R30's care plan regarding use of. The DON contacted therapy during the interview and informed therapy (T)-C stated therapy received the weighted blanket but did not utilize the blanket as realized the blanket would be a tripping hazard. T-C stated therapy ordered the weighted blanket on 7/11/18 and received the weighted blanket on 7/17/18. The Don and RN-B confirmed they did not know the information from therapy regarding the weighted blanket prior to interview with surveyor. DON stated sometimes the IDT team writes will try interventions and they do not work. DON confirmed there was no documentation in R30's notes regarding interventions tried and if the interventions were successful or failed. During the interview with the DON, on 10/25/18, at 2:17 p.m., the activity director (AD)-A stated there is a sensory blanket available in the activity corner and a sensory binder available in R30's room. The DON stated the she did not see the sensory blanket on R30's care plan. During interview on 10/25/18, at 3:37 p.m., the DON stated R30's resident included a note that read resident has been placed off 15 minute checks. DON stated 15 minute check were documented for the month of 9/18, but prior to	F 689		

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F 689	Continued From page 55 that there was no documentation in R30's record 15 minute checks were being implemented as indicated for the intervention added on 6/24/18. The documented sheets provided by the DON showed 15 minute checks started being documented on 8/31/8 at 12:00 a.m. and ended on 9/21/8, at 11:45 p.m. The sheets lacked full documentation of the 15 minutes checks being consistently implemented. The Don stated the facility system was staff on floor to do report immediately following a fall to determine the root cause analysis and implement an intervention. A copy of the report goes to the administrator and I. We review the falls at the IDT meeting every a.m. in our stand up meeting. We talk about interventions put in place and the IDT determines what more can we do for the person falling. DON stated the IDT agrees with what is documented on the sheet for interventions by the staff and if there was a change in interventions it would be documented in the IDT note. The facility policy Fall Risk, dated 11/28/10, indicated Policy: the nursing staff, in conjunction with the primary care provider, consultant pharmacist, therapy staff, and others , will seek to identify and document resident risk factors for falls. Procedure: 8. The staff and primary care provider will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. The facility policy Accident and Incident Investigation, dated 11/28/10, indicated Procedure: 13. Implement preventive measures as appropriate. R15 had been interviewed on 10/22/18, at 4:25 p.m. regarding her stay at the facility and the care	F 689		

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F 689	Continued From page 56	F 689		

received. During the interview, R15 reported several falls, but was unsure of when the falls had occurred. R15 said perhaps it had been two months. When questioned about the reasons for the falls, R15 admitted to having some weakness and had gotten up without calling for help. R15 stated an understanding of her risk for future falls if she would continue to get up unattended. Despite this understanding, R15 said about getting up without staff assistance, "I shouldn't but I will." When asked what staff had done to keep her safe from falls, she was unable to say.

According to an interview on 10/24/18, 9:37 a.m. with nursing assistant (NA)-B, R15 was able to stand and transfer quite well and one staff person could easily assist her using a gait belt with a walker. NA-B said that staff try to keep R15 "up front so she can be supervised but she likes to be in her room to watch TV." NA-B was unsure about other interventions for safety but said she personally, walks by her room often.

The clinical nurse manager, licensed practical nurse (LPN)-B was interviewed on 10/24/18, at 1:29 p.m. about what was being done to keep R15 safe. LPN-B said they give R15 a call-light and remind her to use it, but says, "I think she just forgets to use it." Then LPN-B said, "when she is determined to do something she is going to do it." When asked if the nurses do a root cause analysis to determine why resident fell, LPN-B said this would be done at the interdisciplinary team (IDT) meeting and the results of that finding would be put in a meeting note. LPN-B also stated that they "check on R15 when they walk by" but was not able to substantiate a frequency of checks. When asked to review the resident's record for updated information on any

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interventions initiated, LPN-B said that the resident had a self-locking wheel-chair, but was unable to locate that information on the resident's care plan, notes or remember when this had been initiated.

According to an interview on 10/25/18, 9:34 a.m. the director of nursing (DON) stated an expectation for all nurses to explore the root cause of any fall and come up with a new intervention that might help prevent a fall the next time. DON gave an example of R15, saying the nurse should not merely say "got up unattended", but instead explore the reason why she got up so an appropriate intervention could be initiated.

A review of the medical record and resident care plan indicates R15 was identified as being at "moderate risk for falls" on 9/8/15, and the care plan problem listed as having been updated on 10/20/16. Two interventions were added in 2017: the resident's room being at the "front of the hall for frequent observation" and for the resident to wear hip protectors. No other new interventions were noted as having been added in response to resident falls in 2018. In the medical record, progress notes indicated that resident fell on 8/28/18 , 9/28/18 and 10/10/18. Nurse documentation included the following: "impulsive, frequently transfers self, forgets to turn on call-light and is unaware of her limitations." The only recorded intervention was-- "remind resident that her call light is within reach and to please use it when needing help."

A request was made for R15's incident reports for August through October 2018; reports were received for falls dated: 1.) 8/28/18 at 2:55 p.m., 2.) 9/28/18 at 3:35 p.m., 3.) 10/10/2018 at 4:10

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F 689	Continued From page 58 p.m., 4.) 10/25/2018 at 6:15 a.m. and 5.) 10/25/2018 at 9:50 a.m. The following documentation of the "initial root cause" and description of "initial interventions" corresponding to the listed root cause is as follows (in order of date and time): 1.) Root Cause- resident impulsive, forgets to turn on call light for help. Intervention- remind resident that her call light is within reach and to please use it when needing help. 2.) Root Cause- Resident "forgets" to use her call light and frequently self-transfers. She is "unaware" of her limitations." Intervention- [this area of the form is blank] 3.) Root Cause-Resident is impulsive, unaware of/forgets her limitations. Intervention- [this area on the form is blank] 4.) Root Cause- poor judgment, up arrow [increased] confusion. Intervention- offer bathroom 5.) Root Cause- poor judgment. Intervention- [this area of the form is blank] An example of the facility IDT note was reviewed (August 30, 2018) and there was no area seen where falls or incidents would be documented. R15's name was not listed on the 8/30/18, IDT note even though a fall happened on 8/28/18.	F 689		
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.	F 690		11/28/18

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F 690	Continued From page 59 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper urinary indwelling catheter care in order to prevent and/or reduce the risk for urinary tract infections for 1 of 1 resident (R202) reviewed who had an indwelling catheter. Findings include: R202's facility Admission Record dated 10/25/18,	F 690	Deficiency with ID Prefix Tag F690 shall be corrected. Facility shall ensure proper indwelling catheter care in order to prevent and/or reduce the risk for urinary tract infections. R202 shall received proper indwelling catheter care. All residents shall receive proper indwelling catheter care. The Policy and Procedure for Catheter	

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F 690	Continued From page 60 indicated R202 was admitted to the facility on 10/18/18, with diagnoses that included benign prostatic hyperplasia (BPH-enlarged prostate) with lower urinary tract symptoms. R202's care plan dated 10/19/18, indicated R202 had an indwelling urinary catheter related to BPH with obstruction since June 2015, and the catheter would be managed by nursing. The care plan directed licensed staff to change the catheter every three weeks and for staff to monitor for signs and symptoms of infection. R202's care plan nor physician's order identified how often routine catheter care should be provided. R202's Catheter evaluation dated 10/18/18, included: R202 historically had one urinary tract infections every five weeks and staff would monitor for patency, outputs, appearance of urine and empty collection bag every shift. The evaluation further indicated R202 had an increased risk for urinary tract infections. During an observation on 10/24/18, at 8:11 a.m. R202 was assisted with morning personnel cares by nursing assistant (NA)-B and NA-F. After emptying R202's urine collection bag, R202 was assisted to a standing position by NA-B and NA-F. NA-B donned gloves and used a soapy wash cloth to clean R202's right and left groin, then with the soiled wash cloth proceeded to clean the urinary catheter tube. NA-B then used a washcloth to rinse the areas in the same order. During an interview on 10/24/18, at 8:33 a.m. NA-B confirmed washing R202's groin prior to washing the catheter. NA-B stated the catheter tubing should have been cleaned prior to the	F 690	Care has been reviewed and updated. All nursing personnel shall be reeducated on the policy and procedure and ensuring the tubing is cleansed prior to the groin area. The Director of Nursing or designee shall monitor for continued compliance with this plan of correction through random direct observation 3 times a week of the cleaning of indwelling catheters for one month. Findings shall be reviewed at the January, 2019 QAPI meeting.	

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F 690	Continued From page 61 groin. During an interview on 10/24/18, at 2:53 p.m. clinical manager licensed practical nurse (LPN)-B indicated R202's catheter should have been cleaned prior to washing the groin areas to decrease risk for infection. During an interview on 10/25/18, at 8:40 a.m. director of nursing (DON) indicated R202's catheter should have been washed prior to cleaning the groin. Facility policy Catheter Care (Indwelling Catheter) dated 8/8/18, lacked a procedure for cleaning the catheter tubing. The policy instructed staff of the following: 6) Routine (pericare with soap and water) is performed daily and as needed. 2.) Males: wash glans and adjacent area of penis with soap and water retracting foreskin.	F 690		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §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.	F 755		11/28/18

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F 755	Continued From page 62 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure individual resident destruction of medications for non-controlled substances. This had the potential to affect several residents who had discarded medications. Findings include: During interview on 10/23/18, at 11:03 a.m., trained medication aide (TMA)-A stated the director of nursing (DON) was the person who destroyed medications. During interview on 10/23/18, at 3:20 p.m., the director of nursing (DON) stated I and another nurse destroy medications by placing them into an RX buster (drug disposal system). We highlight the name of the drug listed on a Pharmaceutical Waste sheet and if the name of the drug is not on the list, we write the name of	F 755	Deficiency with ID Prefix Tag F755 shall be corrected. Facility shall ensure individual resident destruction of medications for non-controlled substances. No residents identified as being affected. Policy and Procedure for Medication destruction of non-controlled substances has been reviewed and updated to include the individual resident destruction record. Staff responsible for medication destruction have been educated on procedure and record completion. The Director of Nursing shall monitor this plan of correction for continued compliance by overseeing and assisting with the destruction of all non-controlled medications for the next month. Any findings or concerns regarding the procedure will be discussed at the January, 2019 QAPI Meeting.	

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F 755	Continued From page 63 the drug on the sheet. DON stated the facility started the process of destroying medications this way in June 2018. When asked if there was record for each individual resident medication destruction for non-controlled medications, the DON stated no, we only highlight the name of the drugs we are destroying on the sheets. The instructions on the pharmaceutical Waste sheet read RN (registered nurse)/LPN (licensed practical nurse) highlights the name of the medication placed in the pharmaceutical waste for disposal. Medications need to be highlighted once. There is space provided to add the name of any medication not already listed on the form. Keep this form with the waste container. Provide a copy of the form to the Clean Harbor representative requesting a waste pick-up. The facility policy Medication Waste process, dated 6/26/18, indicated medication disposal into blue drum will take place on a monthly basis and as needed. All unopened, fully dispensed cards can be sent back to pharmacy for reimbursement. Put medications to be disposed of on the shelf in the white basket. For nicotine and Coumadin, wrappers for these medications need to be disposed of as well and can be put on the shelf with medications to dispose of. DON or designee will complete this. Log for medications is kept in the DON office. Highlight medications that are being disposed of, if not on the list, write them in. When drum is full, DON will log into web site for EPA ID number.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		11/28/18

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F 761	Continued From page 64 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 open vials of mantoux solution had a date open and 5 of 5 residents (R202, R203, R204, R49 and R205) had received medication from this vial. Also the facility failed to ensure an insulin pen alerted for a change in direction for 1 of 1 resident (R24) observed to be administered insulin. Finding include: NO DATE OPEN MANTOUX VIAL: On 10/23/18, at 11:03 a.m., observation of the	F 761	Deficiency with ID Prefix Tag 761 shall be corrected. Facility shall ensure that vials of Mantoux solution are dated upon opening and when an order changes and medication is still available, an alert label will be applied to the packaging. The opened and undated vial of Mantoux solution was discarded immediately. The first Mantoux of this solution (Lot# 318159) was administered on 10/5/2018 and last administered on 10/22/2018. Solution was administered within 30 period so it was not expired. R202, R203,	

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F 761	Continued From page 65 facility medication storage room with trained medication aide (TMA)-A identified an open vial of mantoux solution had no date opened indicated. The stock number for the mantoux solution was 318159 and had been received on 5/25/18. The following residents had received mantoux solution administration from the stock number 318159: R202 had a first step tuberculin sensitivity test (TST) administered on 10/18/18. R203 had a first step TST administered on 10/19/18. R204 had a first step TST administered on 10/22/18. R49 had a first step TST administered on 10/05/18. R205 had a first step TST administered on 10/09/18. During interview on 10/23/18, at 11:37 a.m., the director of nursing (DON) confirmed the mantoux vial had no date opened indicated. DON stated we would dispose of the mantoux solution. LABEL: R24 was administered insulin on 10/24/18, at 7:37 a.m., by registered nurse (RN)-C who had been observed to administer 30 units of Lantus SoloStar insulin to R24 via an insulin pen. The label on the insulin pen read 25 units subcutaneously every a.m. RN-C stated the medication administration record (MAR) read give 30 units every a.m. RN-C confirmed there was no indication on the insulin pen there was a change in orders for the amount of insulin to be administered. RN-C stated I never go by the label.	F 761	R204, R49 and R205 were not effected by the vial not being dated. R24's label for insulin was labeled with a "change of direction, refer to chart" sticker. All medications with a label that is different than the MAR have a "change of direction, refer to chart" sticker applied. The Policy and Procedure for Storage of Medications including dating opened vials and Direction Change Labels have been reviewed and updated. All licensed nurses and TMA's have been reeducated on these policies. The Director of Nursing or designee shall monitor this plan of correction for continued compliance through audits of opened vials and order changes that are different from the labeled medication. Audits will be conducted three times a week for a month. Findings will be reported at the January 2019 QAPI Meeting.	

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F 761	Continued From page 66 R24's current physician orders identified an order dated 10/15/18, to give 30 units insulin glargine (Lantus) one time a day. R24's MAR, dated for the month of 10/18, identified the insulin was being given as ordered. During interview on 10/15/18, at 1:19 p.m., the DON was asked what should be done when the label of the medication does not match the dose being instructed to be given on the medication administration record, and there was no indication on the medication container the order had been changed. DON stated she would expect the nurse to go check the physician order in the resident chart and verify the most current order of insulin to be given. DON stated we do have direction change stickers as well. The facility policy Medication Storage in the facility, dated 10/1/11, indicated Policy: Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The facility policy Direction Change-labels, dated 10/24/18, indicated Procedure: 1. When an order changes and medication is still available, a directions changed, refer to chart stick will be applied to the packaging.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		11/28/18

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F 880	Continued From page 67 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 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	F 880		

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F 880	Continued From page 68 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 ensure sanitization of an individualized glucometer for 1 of 1 resident (R45), observed to have a blood sugar check and nebulizer machine equipment for 1 of 1 residents (R23), observed to be administered medication via a nebulizer. In addition, the facility failed to establish an on-going infection prevention program including comprehensive analysis and interpretation of data to identify and respond to possible patterns of infection. Findings include: GLUCOMETER: During observation on 10/23/18, at 3:03 p.m., registered nurse (RN)-C was observed to check R45's blood sugar using an individual glucometer.	F 880	Deficiency with ID Prefix Tag F880 shall be corrected. Facility shall ensure sanitization of glucometers and nebulizers. Facility shall ensure an on-going infection prevention program is established including comprehensive analysis and interpretation of data to identify and respond to patterns of infections. R45's glucometer is sanitized according to updated procedure including to keep surface wet for two minutes. All glucometers are sanitized by keeping surface wet for two minutes. Glucometer Cleaning Policy and Procedure has been reviewed and updated. All licensed nursing staff and TMA have been re-educated on the	

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F 880	Continued From page 69 RN-C applied gloves, wiped the outside of the glucometer with a Super Sani-cloth wipe and laid the glucometer on a Kleenex to air dry. RN-C stated the glucometer had to dry for two minutes after cleansing the machine with the Super Sani-cloth wipe. After allowing the glucometer to air dry, the glucometer was placed in a plastic bag with insulin pens for R45, which was stored in the medication cart. Observation of the Super Sani-cloth wipe container with RN-C identified the label on the container directed allow treated surface to remain wet for a full two minutes. Let air dry. RN-C stated (in regards to the glucometer surface having to be wet for two minutes), I do not know about that, but I wiped it off pretty good. The glucometer was soaked. The facility policy Disinfecting Glucometer, effective date 5/15/18, read Procedure: 1. Wipe all surfaces of glucometer with a Super Sani-cloth to clean the glucometer 2. Throw the wipe away 3. Per manufacturer, wipe surfaces of glucometer again to ensure the disinfection process is completed. 4. Allow glucometer to air dry for two minutes On 10/24/18, at 2:47 p.m., observation of the Super Sani-cloth wipe container with the director of nursing (DON), the DON confirmed what the container label read for disinfecting and what the facility policy read . The DON stated I am going to have to change our policy. NEBULIZER EQUIPMENT: On 10/23/18, at 3:27 p.m., RN-D walked into R23's room to place a vial of liquid medication into a nebulizer machine medication cup. The nebulizer equipment was observed to be all together and there was visible liquid/moisture in	F 880	procedure for cleaning glucometers. R23's nebulizer is cleaned after each use according to policy. All nebulizers are cleaned after each use according to policy. The nebulizer cleaning policy has been reviewed and is appropriate. All licensed nursing staff has been reeducated on the proper cleaning procedure for the nebulizers. The Director of Nursing or designee shall monitor for continued compliance with sanitizing of nebulizers and glucometers through random direct observation of cleaning of the glucometers and nebulizers. These observations will be done 3 times a week for each piece of equipment for one month. Findings will be reviewed at the January 2019 QAPI. The Infection Prevention Program has been reviewed and updated. Infections, both resident and employee, are reviewed weekly at IDT. New infections are also reviewed daily at Stand Up (for residents) and employee illnesses with reportable symptoms are reported to the IP as facility becomes aware. Infections are tracked on a floor plan for residents for trending purposes. Employee reportable illnesses are tracked based on department, signs and symptoms and shift. These tracking documents are reviewed weekly at IDT with any trends identified or sooner if an acute increase of infections is noted. All infection tracking will be analyzed month by month to determine responses needed to a pattern of infections. The analysis and action determined necessary to respond shall be	

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F 880	Continued From page 70 the nebulizer cup where the medication would be placed. When asked if the nebulizer equipment had been cleaned after the last use, RN-D replied it does not look like it. RN-C stated he did not know what the facility policy was for cleaning the nebulizer equipment after each use. RN-C stated he did not know if the nursing assistants cleaned the equipment at bedtime or if the resident cleaned the equipment. On 10/24/18, at 2:47 p.m., DON stated staff were to clean the nebulizer equipment after each use with warm water and let air dry on a clean surface. The facility policy Nebulizer Use, dated 11/28/10, directed 8. The mask, applicator is changed weekly and cleaned at the end of the shift in warm soapy water, rinse and air dry on a paper towel. 9. Rinse nebulizer jar after each use. INFECTION PREVENTION PROGRAM: During an interview on 10/24/18, 12:55 p.m. registered nurse (RN)-A, the nurse responsible for the facility Infection Prevention program, stated that she gains information about the facility infections by attending report each work day and then writes that information in a log book and places a mark on a facility map. She also stated that at times she has a "lot on her plate" and so she makes a note and puts it on her bulletin board to remind her to complete the work later--this could be a day to several days later. When asked about documentation related to on-going analysis of things such as trends in types of infection, spread or frequency of infections and so on, she said that they might talk about it at their weekly interdisciplinary team meeting (IDT). She also said that while in IDT they would discuss the type of germs associated	F 880	documented. The Director of Nursing shall monitor continued compliance with this plan of correction through review of forms used for tracking, involvement in analyzing and interpretation of data to ensure timely and appropriate response to any patterns or trends identified. Infection Control meetings will be held monthly for the next three months to ensure proper data collection, analysis and responses to identified trends, causes of infections and educational needs for staff. Findings shall be reviewed at the QAPI meeting in January, 2019.	

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F 880	Continued From page 71 with any current infections, or in response to a possible spread of infection, they might decide to do an audit of care, and then come up with a response plan. For instance, she stated that she had done hand-washing audits and a "lot of training" on hand washing and perineal care (cleaning of the urogenital region) when she noticed more urinary tract infections one month. When asked about documentation of these IDT discussions related to infection prevention or response to identified concerns, RN-A said that she was unsure if anyone did this. She added that someone might write an IDT note in a resident's chart if they had an infection, but she did not believe anyone took notes related to their facility infection plan during IDT meetings. When asked about how she communicates an infection concern or plan from the IDT meeting to the facility staff, she thought this would be done by the unit clinical manager. On 10/25/18, 8:56 a.m. a record review of the facility infection log was completed. While the record did show a monthly listing of resident infections, the log did not include documentation showing analysis of the collected data that could be used by the facility to identify such things as associated or causative factors including breaks in infection control practices, educational needs, increased or altered risks related to internal or external factors. Furthermore, the record did not include documentation of actions taken within the facility in response to identified infections. The record failed to show evidence the facility was actively looking for correlations, trends or patterns of infection within the facility. Following the record review, RN-A was interviewed again on 10/25/18, at 9:15 a.m. and	F 880		

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F 880	Continued From page 72 verified that the facility did not have documentation of any analysis or a response to the data from the monthly infection log. At that time RN-A said, "there isn't really...we don't really do that." On 10/25/18, 9:20 a.m. the director of nursing (DON) was interviewed about expectations related to the facility infection prevention plan. When asked about their practices related to the tracking and analyzing portion of their plan, DON said that it was an expectation of the infection prevention nurse to track all infections and anything done in response to noted problems, such as audits. DON was unaware of any documentation in the facility where they may show evidence of their work related to analysis, planning or work towards preventing future outbreaks of infection. DON did say that currently the facility is not showing any trends but was unable to show evidence of written data analysis that supports this belief. Records were requested to show evidence of on-going analysis and interpretation of infection data that was collected and any response to that information. A provided document titled Quality Assurance Performance Improvement, April 1st, 2018 through June 30th, 2018, 2nd quarter provided the following information: the number of acute illnesses, how many were acquired within the facility and how many were urinary tract infections. No other types of infection were delineated except for a statement related to a case of Norovirus in April. Below the quantified list, a list of bacterial organisms was included without any information associating the bacterium to the infections listed. The document does not include any information related to what was done	F 880		

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F 880	Continued From page 73 in response to the listed infections or any plans to prevent future infections. No month to month analysis is noted for trending purposes. The facility also provided a document titled "Quality Assurance and Performance Improvement Meeting Minutes, August 18, 2018 which included a statement saying an RN had reviewed the infections for the quarter and identified a spike in June, but no trends. No other information related to analysis, actions or plans were written in the document provided. A request was made for evidence of any audits done related to handwashing or perineal care over the last three months including any retraining done in response to the audits. The request was returned with a comment that said, "annual skills fair," along with a list of attendees, but no audits were provided. Additionally, two documents titled Annual Skills Check Evaluation--CNAs (certified nursing assistants) were provided for two different nursing assistants. One Annual Skills Check document was listed as being due July 2018, with a completion date of October 1, 2018. The other was listed as being due June 2018, and completed July 7, 2018. No associated audit was provided. Policies related to the facility infection prevention program were requested. A portion of a policy titled Infection Control Program with a footnote stating a date of 2010 was provided (sections one, two and six). The document included the following statements: --"The facility establishes a program under which it ...investigates, controls, and prevents infections in the facility" --"communicates the findings from data collection to the nursing home and directs	F 880		

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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 880	Continued From page 74 changes in practice based on identified trends, government infection control advisories and other factors"	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interviews, and document review, the facility failed to establish a comprehensive antibiotic stewardship program that includes monitoring for resident outcomes in relation to antibiotic use; tracking antibiotic measures and reporting to relevant staff and clinicians on such measures and outcomes. Additionally, the facility failed to provide staff clear protocols for antibiotic use or a plan for addressing the inappropriate use of antibiotics, or methods of communicating concerns about antibiotic use with prescribing clinicians. This had the potential to affect several residents in the facility. Findings include: According to an interview on 10/24/18, 12:55 p.m. with registered nurse (RN)-A, who is responsible for the facility Infection Prevention program and Antibiotic Stewardship, said she gains information about facility infections by attending report each	F 881	Deficiency with ID Prefix Tag F881 shall be corrected. Facility shall ensure a comprehensive antibiotic stewardship program that includes monitoring for resident outcomes in relation to antibiotic use; tracking antibiotic measures and reporting to relevant staff and clinicians on such measures and outcomes. Facility shall provide staff clear protocols for antibiotic use or a plan for addressing the inappropriate use of antibiotics, or methods of communicating concerns about antibiotic use with prescribing clinicians. The Antibiotic Stewardship Program has been reviewed and updated to ensure antibiotic use protocols and a system to monitor antibiotic use are included. Policies and Procedures and data collection forms for analysis have been reviewed and updated for the Antibiotic	11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING ______ B. WING ______	C 10/26/2018

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F 881	Continued From page 75 work day and after that logs the information in a tracking book. The nurses working directly with residents are the persons responsible for contacting the resident's physician when there is suspicion of an infection; however, after residents are started on an antibiotic, RN-A utilizes a form which is designed to assure signs and symptoms meet the minimum criteria for their use. When asked what is done with the information, RN-A said it is placed in a binder in her office. This decision making tool is not used by the nurses who are in contact with the medical provider prior to the initiation of antibiotics; nor is the form kept in the resident's medical record. When asked what actions are taken if the form shows antibiotic use is not indicated for a resident's symptoms, RN-A stated that she places a copy of the physician's documentation with the form in the binder. RN-A also explained that nurses working with the residents should be assessing each resident during the time they are receiving antibiotics and writing a note in their chart. RN-A was asked about guidelines for the nurses so they would know what to assess or chart and she said she thought the unit clinical managers did this. RN-A does not do chart audits of documentation for evidence of effectiveness or complications related to antibiotic use. RN-A was asked if attempts were made to communicate with the facility medical providers regarding antibiotic use, patterns of use or any concerns with prescribing. RN-A replied that the facility Medical Director is made aware during Quality Assurance and Performance Improvement meetings (QAPI) but RN-A does not contact physicians directly unless she is made aware of antimicrobial resistance in a specific case. Additionally, RN-A was questioned about what sort of analysis was done with the data gathered,	F 881	Stewardship Program. When an antibiotic is started, the Infection Surveillance Definition Worksheet is filled out. Information is then transferred onto the Facility Wide Review of Antibiotic Orders. A Summary/Analysis form shall be used to analyze data at the end of each month. Data will include: total number of antibiotics received, indication document for antimicrobial, antimicrobial indication aligned with Loeb criteria, antimicrobial starts with provider in house or outside provider. Antibiotic Time Out will be completed with provider 1-3 days after antibiotic use by the CNM or IP and document provider response in the medical record. Data will be reviewed daily at Stand Up, weekly at IDT and on a monthly basis. Analysis will be documented and maintained with supporting data and presented at QAPI Meetings. The Director of Nursing shall monitor continued compliance of this plan of correction on a monthly basis by auditing the data collected and being directly involved in the analysis to ensure the program is comprehensive and effective in monitoring antibiotic use. Findings will be reviewed at the January 2019 QAPI Meeting.	

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F 881	Continued From page 76	F 881		

to which she stated, she gave a report at QAPI but does not do analysis of trends by prescriber, by type of infection, type of antimicrobial or any other analysis.

On 10/25/18, at 9:20 a.m. the director of nursing was interviewed and said she was unaware of any analysis of antimicrobial use. She did state an expectation for nurses to do assessments specific to the type of infection a resident may have, and document those findings on a daily basis while on antibiotics.

Antibiotic Stewardship policies and procedures were requested and a one page policy titled Antibiotic Stewardship, showing as having been updated November 1, 2017, was provided. This document indicates an expectation for the Infection Preventionist to "review each antibiotic for appropriate indication, route and duration of therapy to track and monitor trends of antibiotic use." The policy directs staff to monitor "resident's temperature every shift while resident is taking antibiotics" but fails to instruct staff to monitor for antibiotic effectiveness, symptoms specific to the infection or to monitor for side-effects or negative outcomes related to antibiotic use. While the policy does state that in the case where antibiotics are ordered but do not fit the indications, the medical provider will be asked to explain the rationale in the electronic health record. The policy does not state who should contact the provider, when or how soon this should be done. Neither does the policy indicate the Medical Director's role in working with the prescribers, in reviewing any trends /concerns in antibiotic prescribing or in support of the Antibiotic Stewardship program.

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

Electronically delivered

November 14, 2018

Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, MN 55927

Re: State Nursing Home Licensing Orders - Project Number S5344031

Dear Administrator:

The above facility was surveyed on October 22, 2018 through October 26, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5344023. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

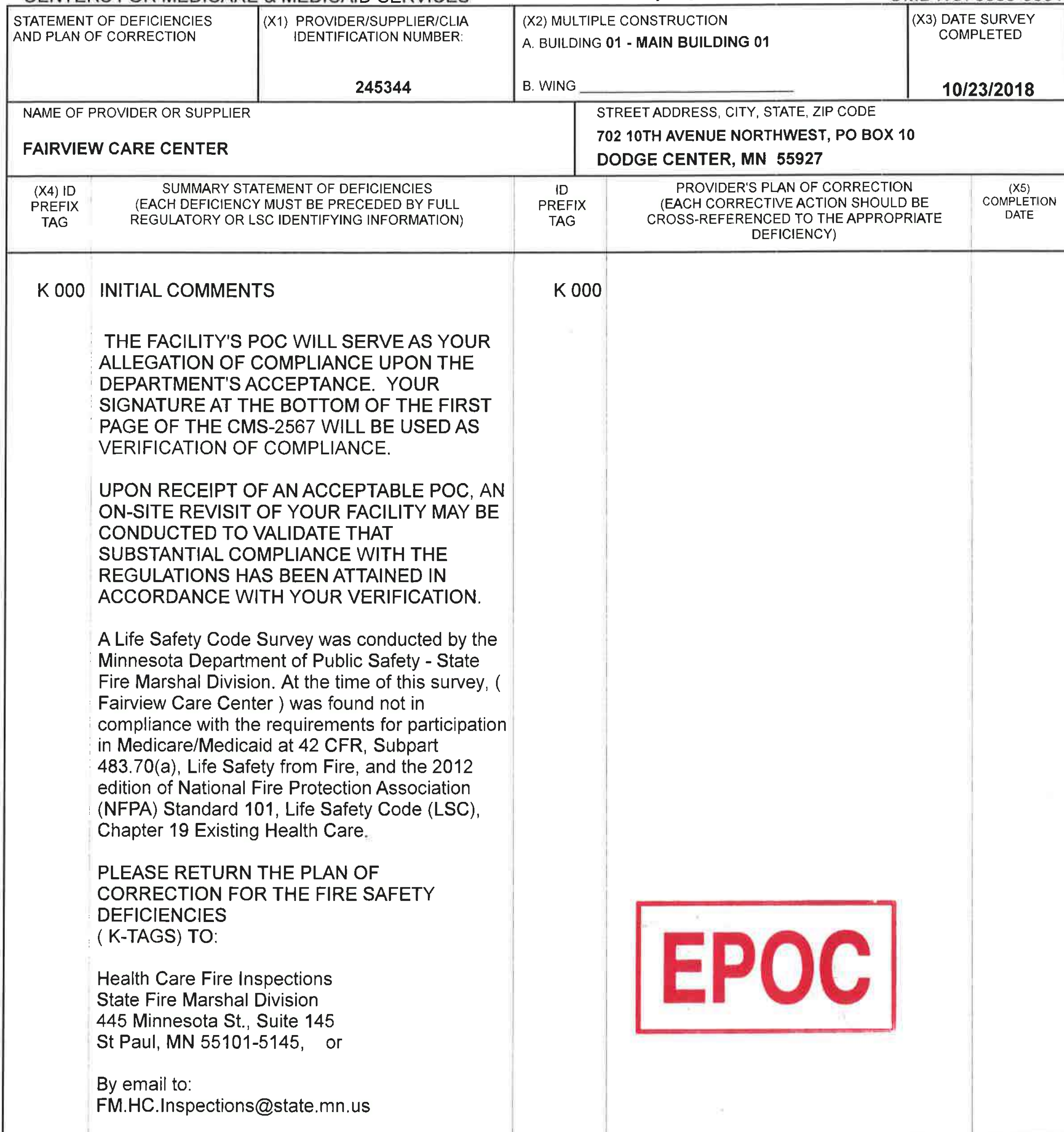
You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us



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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**10/23/2018**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Fairview Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/21/2018

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

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Fairview Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1975 and was determined to be of Type II(000) construction. In 1997, addition was constructed to the North Wing that was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 362	Corridors - Construction of Walls	K 362		11/28/18

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K 362 SS=F	Continued From page 2 CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating ______________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.6.2, 19.3.6.2.7) This deficient practice could affect the safety of all (53) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 10/23/2018, observations and staff interview revealed the following: During the walk-through of the facility - the Furnace Room was found to have penetration in	K 362	Deficiency with ID Prefix Tag K362 has been corrected. The identified penetration in the furnace room around the electrical conduit has been sealed off with fire caulk. This was completed by the Director of Maintenance on 10/24/2018. The Director of Maintenance is responsible for monitoring continued compliance of this plan of correction.	

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K 362	Continued From page 3 the gypsum board around electrical conduit This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 362		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (53) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 10/23/2018, observations and staff interview revealed the following: During the walk-through of the facility - unsecured electrical panels were found in the resident corridors of Wing 100 and 200	K 511	Deficiency with ID Prefix Tag K511 has be corrected. The identified unsecured panels had new locks installed by Hicks Electric on 11/9/2018. The Director of Maintenance is responsible for monitoring continued compliance with this plan of correction.	11/28/18

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K 511	Continued From page 4 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This **REQUIREMENT** is not met as evidenced by: The facility failed to comply with Life Safety Code (19.5.2.1, 9.2) This deficient practice could affect the safety of all (53) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 10/23/2018, observations and staff interview revealed the following: During documentation review, the most current testing date of the facility fire dampers was not available for review. During the walk-through of the facility - the Furnace Room was found to have combustible items stored in close proximity to the furnace	K 521	Deficiency with ID Prefix Tag K 521 has been corrected. The Fire Dampers were inspected and tested on 8/31/2016. This test was documented on the Custom Alarm Annual Fire Alarm and Emergency Communication Inspection and Testing form and emailed to Steve Jurrens, Deputy State Fire Marshall on 10/23/2018. Acknowledgement of receipt of form was received on 10/23/2018. The combustible items were removed on 10/23/2018. Caution tape has been placed on the floor indicating areas that are not to be used for storage. Director of Maintenance is responsible for monitoring continued compliance with this plan of correction.	11/28/18

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K 521	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (53) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include:	K 914	Deficiency with ID Prefix Tag K914 has been corrected. Outlet polarity was included on checklist already in use and reviewed by Fire Marshall. The form has been updated to clearly state "Polarity". The Director of Maintenance is responsible for monitoring continued compliance of this plan of correction.	11/28/18

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K 914	Continued From page 6 On facility tour between 10:00 AM and 01:00 PM on 10/23/2018, observation and documentation reviewed revealed the following: During documentation review of electrical outlet testing - outlet polarity was not part of the records presented for review This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		11/28/18

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K 920	Continued From page 7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4., 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (53) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 10/23/2018, observations and staff interview revealed the following: During the walk-through of the facility - microwave and refrigerator in the Staff Break / Vending Area were found connected to power strips This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	Deficiency with ID Prefix Tag K920 has been corrected. The identified power strips were removed on 10/23/2018. The facility shall be checked on a monthly basis for proper use of power strips. The Director of Maintenance shall monitor continued compliance of this plan of correction.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		11/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/23/2018

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K 923	Continued From page 8 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (5.1.3.3.2, 5.1.3.3.3, 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect the safety of all (53) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 10/23/2018, observations and staff interview revealed the following:	K 923	Deficiency with ID Prefix Tag K923 has been corrected. The identified exhaust had the motor replaced on 11/1/2018 by Harris Mechanical. All cylinders were removed from the facility by AirGas on 10/24/18. Empty and Full signs have been placed in room for the liquid oxygen tanks. The Director of Maintenance shall monitor continued compliance of this plan of correction.	

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/23/2018**

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K 923	Continued From page 9 During the walk-through of the facility - the Oxygen storage room exhaust did not appear to be operational, there was no clear separation of cylinders, and empty/full cylinder signage was not displayed This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923		

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	00103	A. BUILDING: ______ B. WING ______	C 10/26/2018

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2 000	Initial Comments	2 000		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 22, 23, 24, 25, & 26, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, complaint investigation(s) were also	2 000		

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2 000	Continued From page 2 completed at the time of the licensing survey. An investigation of complaint H5344025 was completed. The complaint was substantiated at MN Rule 4658.0520 Subp. 1. (0830).	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		11/28/18

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided in written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training, and topics covered in the training. This had the potential to affect all 51 residents in the facility, and resident representatives/families. Findings Include: Review of the facility's Admission Packet and facility information, lacked evidence of a description of facility staff training for the care of residents with dementia/Alzheimer's disease. On 10/23/18, at 4:20 p.m. the administrator stated they just added to the resident handbook today, information on Dementia training. The administrator stated she was not aware of the requirement prior to today. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update the admission packet to include required information for consumers regarding dementia training in the facility. The quality assessment and assurance committee could review the revised document to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable	2 560		11/28/18

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2 560	Continued From page 4 objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 resident (R45) reviewed for hearing impairment. Findings include: On 10/22/18, at 2:00 p.m. during an observation and interview R45 stated he has not had a hearing aid and stated it was missing. R45 stated he would like to get a new hearing aid. R45 was observed to not have hearing aids in place. R45 was re-admitted to the facility on 7/9/18, per the admission record with diagnoses of chronic gout and malaise. R45's care plan created date 6/16/17, with a revision date of 7/18/18, included, "Resident is very hard of hearing and has right hearing aid. Resident states he sees well and does not wear glasses. Resident accepted all In House Services." Goal dated 6/16/17 included: Resident will continue to see and hear well with current aides." Review of the admission Minimum Data Set (MDS) an assessment dated 7/16/18, identified	2 560	Corrected.	

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2 560	Continued From page 5 R45 as utilizing no hearing aids for hearing. The resident had a BIMS score of "5" (meaning severely impaired cognition) and the resident was sometimes understood and understands. Cognitive/Communication/Hear/Vision progress note dated 7/9/18 included, "Late Entry: Note Text: Resident is alert and oriented to self. Unable to state where he was at or the date. Resident communicates in English but is sometimes difficult to understand due to muffled speech. Resident does not wear dentures, and has no teeth left of his own. Resident is very HOH [hard of hearing] but does not wear hearing aids. Resident states he sees well and does not wear glasses." On 10/24/18, at 7:56 a.m. nursing assistant (NA)-A stated R45 did not wear hearing aids and stated she was not aware if he had hearing aids. NA-A stated the hearing aids would be listed on his cheat sheet and stated the cheat sheet for him did not indicate he had hearing aids. On 10/24/18, at 10:34 a.m. social services (SS)-A stated prior admissions to the facility a long time ago he had hearing aids. SS-A stated when he came back to us this admission, he did not having hearing aids. SS-A stated R45 was signed up for the audiology service and will be seen when they come to the facility next. SS-A stated R45's admit date to the facility for his current stay was 7-9-18, and verified R45's care plan indicated R45 had a right hearing aid. On 10/25/18, at 10:50 a.m. the director of nurses (DON) stated the clinical mangers are in charge of the care plan and we review care plans before their care conferences. The DON stated her expectation was when a resident was a	2 560		

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2 560	Continued From page 6 readmission to the facility; the clinical managers are to review the care plan, to ensure they would be accurate for the current stay. The DON stated social services would write the dental, hearing and vision care plans. The DON stated R45's hearing care plan was last revised 7/18/18, by the social worker. The Care Plan policy reviewed 12/4/13 included, "The care plan will address the needs, strengths, and preferences identified in the comprehensive resident assessment." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develop care plans to address resident specific concerns. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		11/28/18

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2 570	Continued From page 7	2 570		
	guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan with fall interventions for 1 of 4 residents (R30) reviewed for accidents.		Corrected	
	Findings include:			
	R30's quarterly Minimum Data Set (MDS) an assessment, dated 9/26/18, indicated R30 had severe cognitive impairment, required limited assist of one person for transfers and ambulation, had falls since admission, two with no injury and two with injury.			
	R30's current care plan indicated Focus: resident is at risk for falls. See most current Faber Fall Risk Data sheet for details. Safety Checks due to resident history of frequent falls. Interventions dated 6/22/18, included Faber fall risk evaluation to be completed upon admission, after a fall, with a significant change, quarterly and as needed (PRN). Instruct/remind resident to use call light when needing assistance. Monitor resident for steadiness when ambulating. Staff to assure resident receives assistance when needed. Interventions dated 8/29/18, included provide distraction such as folding towels. Resident does not use wheelchair. Use walker at all times. While resident is sitting/lying, walker is to be out of walking path to prevent resident bumping into it and tripping/falling as resident does have poor vision. Resident wears hip protectors. When			

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2 570	Continued From page 8	2 570		

resident becomes restless, offer to go for a walk with assist of 1, Front Wheel Walker, and gait belt. Interventions added 9/14/18, indicted offer distractions when resident becomes impulsive, to include folding towels/clothes, conversing, going for a walk, participating in the day's activities, having a snack, etc. Cue/assist to toilet upon rising, between meals, at bedtime and during night when awake and willing to toilet, as well as with other interventions.

During observation on 10/24/18, 7:59 a.m., R30 was assisted to the bathroom by an unidentified nursing assistant. At 10:11 a.m., R30 stood up from being seated on her bed, walked out of her room and stated to an unidentified nursing assistant I have to find my purse. Nursing assistant asked R30 do you want to lay down or go up front and fold laundry. R30 stated I am looking for my laundry basket. Nursing assistant asked R30 if she wanted a drink, water, or Kool-Aid that was being passed out to residents. Nursing assistant gave R30 a drink of water and assisted R30 back out to the main living room area, seated R30 in a chair at the table and gave R30 a puzzle to work on.

R30's Guidelines for Nursing Note Documentation of Incidents, Quality Assurance Report Investigation of Incident and resident progress notes identified the following interventions were implemented:
On 6/27/18, 7:00 p.m. unwitnessed fall. Intervention: One to one.
On 6/28/18, 13:16 (1:16 p.m.) IDT team reviewed fall from last night. Will talk with activity staff about getting resident a sensory blanket.
On 7/11/18, 9:37 a.m. IDT reviewed two falls from 7/10/18. Staff provide 1:1 frequently or involve her in many activities.

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2 570	Continued From page 9	2 570		

On 8/30/18, 10:33 a.m., IDT review. Resident had self-transferred from bed and fell on the floor next to bed at 11a.m. (8/29/18). Will also see about having her listen to music while in her room.
On 8/31/18, 11:40 a.m., IDT team reviews fall from 8/30/18. Team has also discussed trying lavender spray/soap to help with the impulsivity in resident.

R30's care plan lacked to include any of the interventions discussed after falls from list above.

During interview on 10/25/18, at 1:33 p.m., the director of nursing (DON) confirmed R30's care plan with the interventions dated as above had not contained any new interventions which were not included in R30's comprehensive care plan to prevent falls.

Policy Accident and Incident Investigation, dated 11/28/10, indicated Procedure: 13. Implement preventive measures as appropriate.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develop care plans to address to address resident specific concerns.
The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.
The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.

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

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2 685	Continued From page 10	2 685		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to complete a summary of the resident stay (recapitulation) for 1 of 1 resident (R53) reviewed for closed record review. Findings include: R53 closed medical record face sheet indicated the R53 was admitted following a stay at St. Mary's hospital for recurrent falls, decline in functional status and acute renal failure with tubular necrosis. R53 discharged from the facility on 8/8/18, to a REM home with home health therapy provided by Comfort Care. Review of the medical record revealed there was no evidence of the recapitulation of resident's stay document. On 10/25/18, at 9:20 a.m. the director of nursing (DON) stated they facility must have sent the original copy of the discharge summary that was completed with the resident, as the facility had not been able to find a copy of it. The DON stated she expected the facility to have a copy of the discharge summary in the resident's record. The Discharge/Transfer of the Resident policy dated 11/22/2010, directed staff to, "6. Complete	2 685	Corrected	11/28/18

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2 685	Continued From page 11 a discharge summary and post discharge plan of care form. a. Include a list of medications with instructions in simple terms. Do not use medical terms or abbreviations. b. Include instructions for post discharge care and explain to the resident and/or representative. c. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care form. This included release of medications. d. Give copy of the form to the resident and/or representative or person(s) responsible for care. e. Place signed original of form in the medical record." SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the need to do a discharge summary as outlined in the regulation/order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 685		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		11/28/18

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2 830	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for root cause analysis related to falls and implement interventions to minimize the risk for injury for 2 of 4 residents (R30 and R15) reviewed for accidents. This resulted in actual harm for R30. Findings include: R30's quarterly Minimum Data Set (MDS) an assessment, dated 9/26/18, indicated R30 was admitted to the facility on 6/22/18, had severe cognitive impairment, required limited assist of one person for transfers and ambulation, had falls since admission, two with no injury and two with injury. R30's current care plan indicated Focus: resident is at risk for falls. Safety Checks due to resident history of frequent falls. Interventions dated 6/22/18, included Faber fall risk evaluation to be completed upon admission, after a fall, with a significant change, quarterly and as needed (PRN). Instruct/remind resident to use call light when needing assistance. Monitor resident for steadiness when ambulating. Staff to assure resident receives assistance when needed. Interventions dated 8/29/18, included provide distraction such as folding towels. Resident does not use wheelchair. Use walker at all times. While resident is sitting/lying, walker is to be out of walking path to prevent resident bumping into it and tripping/falling as resident does have poor vision. Resident wears hip protectors. When resident becomes restless, offer to go for a walk with assist of 1, front wheel walker (FWW), and	2 830	Corrected	

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2 830	Continued From page 13 gait belt. Interventions added 9/14/18, indicted offer distractions when resident becomes impulsive, to include folding towels/clothes, conversing, going for a walk, participating in the day's activities, having a snack, etc. Cue/assist to toilet upon rising, between meals, at bedtime and during night when awake and willing to toilet, as well as with other interventions. R30's Faber Fall Risk Data, dated 9/26/18, indicated significant risk for falls. During observation on 10/24/18, 7:59 a.m., R30 was assisted to the bathroom by an unidentified nursing assistant. At 10:11 a.m., R30 was seated in a chair at a table in the main living room area. R30 stood up and an unidentified therapy person asked R30 if she needed to use the bathroom, R30 replied "Yes." R30 was ambulated with a walker and gait belt to her room and an unidentified nursing assistant further assisted R30 to toilet. Once in her room R30 stated I want to sit on my bed for a minute. R30 stood up from being seated on her bed, walked out of her room and stated to the nursing assistant I have to find my purse. Nursing assistant asked R30 do you want to lay down or go up front and fold laundry. R30 stated I am looking for my laundry basket. Nursing assistant asked R30 if she wanted a drink of water or koolaid that was being passed out to residents. Nursing assistant gave R30 a drink of water and assisted R30 back out to the main living room area, seated R30 in a chair at the table and gave R30 a puzzle to work on. R30 had not been toileted while in her room but was moved from her bed to the living room area. R30's Guidelines for Nursing Note Documentation of Incidents, Quality Assurance Report Investigation of Incident, physician	2 830		

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2 830	Continued From page 14 progress notes, resident progress notes and therapy notes included the following: -6/22/18, at 22:50 (10:50 p.m.) admission, resident is alert to self, very forgetful and impulsive. Oblivious to her own safety and limitations. Keeps standing and trying to ambulate independently and is very unsteady. -6/23/18, at 0830 (8:30 a.m.), self transferred from wheelchair (w/c) in hallway, lost balance and fell next to w/c hitting her head on the floor. Resident wearing neck brace when fall occurred. Root cause of fall: resident has history of falls related to confusion and dementia. Initial intervention to prevent further falls: use of wheelchair for transportation. However, R30 was already utilizing a wheelchair. -6/23/18, at 5:10 p.m., sitting in w/c at the table in day room, from across room staff saw resident push away from the table to stand, turn slightly and crumple to the ground, landing on butt. No root cause was documented and no new interventions were implemented. -6/23/18, at 18:15 (6:15 p.m.), unobserved. Second fall of the evening. Found sitting on bottom next to wheelchair. Denied hitting head, stated right buttock was sore. No injuries observed. No root cause was documented and no new interventions were implemented. -6/24/18, at 9:30 a.m. resident slipped out of w/c landing on floor twice. Slipped and landed on elbows and knees with forehead on floor first time at 0900 (9:00 a.m.), slipped under table and found sitting on her bottom second time at 0930 (9:30 a.m.). Root cause: weakness, confusion and leaning over arms of w/c. Interventions: close monitoring and 15 minute checks. -6/24/18, at 12:30 p.m., fell in dayroom. No root cause was documented and no new interventions were implemented. -6/25/18, IDT note at 11:52 a.m. Team reviewed	2 830		

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2 830	Continued From page 15 falls from the weekend. Resident has been assist of two with transfers since admission. Her room is located near the nurses desk. She will be evaluated by therapy today. Therapy will also be getting her a self-locking wheelchair. Will continue to monitor resident frequently. The note lacked documentation by the IDT for root cause analysis for the falls occurring on 6/23/18 and 6/24/18, to determine appropriate interventions. -6/25/18, at 14:45 (2:45 p.m.) resident seen resting in bed at 2:15 p.m. and as staff passed her room at 2:30 p.m. she was noted to be laying on the floor next to her bed. No root cause was documented and no new interventions were implemented. -6/26/18, at 2:45 p.m. IDT team reviewed fall from yesterday afternoon. Resident is participating in PT (physical therapy)/OT (occupational therapy), they are working on getting her a self -locking wheelchair. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. R30's physician progress note, dated 6/26/18, for admission to the facility indicated diagnosis of dementia, recurrent mechanical falls, recent C7 lateral mass fracture requiring C-collar. Patient admitted Friday and no therapy until Monday. Patient is very impulsive and regularly transfers, hence fell seven times over the weekend. IDT (interdisciplinary team) addressed first thing Monday morning. Assessment/Plan: staff will review orthostatic BP/P (blood pressure/pulse) in three days. IDT continues to review modalities with therapy to minimize falls. Minimal medications. Labs noncontributory. Current co-morbidities, ADL (activities of daily living) need/level of debility require skilled care/therapy. -6/27/18, 7:00 p.m. unwitnessed fall. Resident toileted at about 6:30 p.m. and then went out to sit in w/c next to the nurses cart. As this nurse	2 830		

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2 830	Continued From page 16 entered another residents room to give a medication this resident stood up and tumbled forward onto the floor. Found on her hands and knees and as this writer called for assist she stood up on her own and started to fall backwards as this writer caught her and guided her to the chair. Root cause: confusion and residents inability to know limitations and safety. Intervention: One to one. -6/28/18, at 13:16 (1:16 p.m.) IDT team reviewed fall from last night. Resident is very impulsive and had been doing one to one time throughout the night with a few staff. Resident is participating in PT/OT for strengthening. Will talk with activity staff about getting resident a sensory blanket. Will also obtain hip protectors for resident. Therapy is also looking into getting a weighted blanket for resident to try out. Continuing to monitor resident and provide assistance frequently. However, the note lacked to include documentation of root cause analysis to determine an appropriate intervention to implement. R30's care plan lacked to include the interventions of sensory blanket and weighted blanket. -6/29/18 - OT therapy note indicated the patient's new self-locking wheelchair arrived. - 7/2/18, at 9:30 a.m. aide assisted resident to table to organize cards and aide locked breaks. Aide went back to independent DR (dining room), turned around and saw resident standing, stumbled and tripped on her own feet, landing on her right side. No root cause was documented and no new interventions were implemented. -7/3/18, at 10:14 a.m., IDT team reviewed fall at 9:30 a.m. Resident has a self- locking wheelchair and hip protectors. Staff involve resident is many activities to keep her preoccupied. She will play with cards or fold towels. Resident does have very poor vision as well. Will continue to monitor	2 830		

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2 830	Continued From page 17 resident. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -7/8/18, at 10:35 a.m., self transferred, lost balance while standing up, stumbled over w/c foot pedals and fell to floor landing on her right shoulder and hip. Intervention: removed w/c foot pedals. There was no documented root cause analysis. -7/9/18, at 10:38 a.m., IDT reviewed fall from 7/8/18. Resident is working with PT/OT. She has a self-locking wheelchair. She does not know to wait for help and will do things on impulse. Resident does have dementia. She also wears hip protectors. Staff encourage her to participate in activities or play cards, fold towels, color, etc. Resident does have poor vision as well. Continuing to monitor resident. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -7/9/18, at 3:00 p.m., resident sitting at table in day room with towels, magazines and markers. Resident left unattended for few minutes and she stood up and walked into day room. Staff came around the corner to see her stumble and crumple to the floor. Root cause: inability to be aware of own safety limitations. Interventions: one to one. There was no documented IDT review of the fall for 7/9/18, at 3:00 p.m., to determine root cause analysis and an appropriate intervention to reduce falls from recurring. - 7/10/18, at 2:15 p.m. Resident was sitting at table in day room with magazines and playing cards. Nurses were in report for shift change. Resident got up independent and began to ambulate. Stumbled on her own feet and fell to the floor. Witnessed by CNA (certified nursing assistant) who was unable to reach resident fast enough to prevent fall. Root cause: confusion and	2 830		

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2 830	Continued From page 18 forgetfulness. Does not realize her own limitations. Intervention: one to one. There was no documented root cause analysis. - 7/10/18, at 6:30 p.m. Activity staff were doing a 1:1 with resident. Another resident asked the activity aide a question and when she turned away to answer the person R30 got up, started to walk and fell hitting her head. The fall was witnessed by the unit secretary. Resident hit the right side of her head near the temple area on the stand. Root cause: very impulsive, forgetful, does not understand or remember her limitations. Intervention: one to one. There was no documented root cause analysis. -7/11/18, at 9:37 a.m. IDT reviewed two falls from 7/10/18. Resident does become impulsive and has a short attention span. She does have dementia and does not understand to ask for help when needing to ambulate/transfer. Staff provide 1:1 frequently or involve her in many activities. She has a self-locking wheelchair and hip protectors, and she is working with PT/OT. Therapy is working on getting her a weighted blanket to possibly help with the impulsiveness (continues to be mentioned from previous fall). Will continue to monitor resident. R30's care plan lacked to include staff provide 1:1 frequently. There was no documented root cause analysis of the falls on 7/10/18, to determine appropriate interventions to implement. -8/3/18, IDT team. Resident participates in PT/OT. She is doing well. She is assist of one with FWW to all destinations. Resident does not use a wheelchair. - 8/11/18, at 8:15 p.m. Resident ambulating in the hallway looking for her sister. Apparently stumbled and fell to floor, unwitnessed. Root cause: oblivious to own safety and limitations. There was no review for root cause analysis to determine an appropriate intervention.	2 830		

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2 830	Continued From page 19 There was no documented IDT review of the fall for 8/11/18, at 8:15 p.m., to determine root cause analysis and an appropriate intervention to reduce falls from recurring. -8/13/18 room change to room 110 to be right next to the nurses station. -8/14/18, at 10:30 a.m. Resident found on floor next to table in main lobby. Root cause: confusion. Interventions: provide distractions, activities and one to one. There was no review for root cause analysis to determine if the interventions implemented were appropriate. There was no documented IDT review of the fall for 8/14/18, at 10:30 a.m., to determine root cause analysis and an appropriate intervention to reduce falls from recurring. -8/29/18, at 4:40 a.m. Resident was found lying on the floor in room 118. Resident obtained a large, deep laceration on the left forehead measuring 3 cm (centimeters) long. Resident was up and down all night. She had been toileted every hour. Both aides working the hall were helping other residents when her fall happened. Root cause: wandering unattended with an unsteady gait. Intervention: needs to be monitored more closely. There was no documented root cause analysis of the fall to determine appropriate interventions to implement. -8/29/18 at 4:06 p.m. IDT team review. Resident was wandering in the halls and she fell and hit her head. Resident is assist of one for all transfers and ambulation with gait belt and FWW. Resident wears hip protectors. She has very poor vision and dementia. She does not remember to ask for assistance. Resident is also impulsive. Her room is located next to the nurses desk. Staff encourage resident to participate in different activities to include folding towels. Redirection is not always effective when resident becomes impulsive. No changes made at this time. There	2 830		

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2 830	Continued From page 20 was no documented root cause analysis to determine why R30 was wandering the halls and an appropriate intervention to reduce recurrence of falls. -8/29/18, at 11:00 a.m. Resident self transferred from bed and fell on floor next to bed. There was no review for root cause analysis to determine an appropriate intervention. -8/30/18, at 10:33 a.m., IDT review. Resident had self-transferred from bed and fell on the floor next to bed at 11a.m. (8/29/18). Resident is located across from the nurses desk. She is encouraged to participate in many activities, and likes to fold towels. Staff provide 1:1 at times. She wears hip protectors and does not use a w/c as this was a safety issue. Resident is walked to all destinations with FWW and gait belt and assist of one. Therapy will see about using the weighted blanket when resident is taking naps or when sleeping at night (repeat of weighted blanket use). Will offer warm blankets. Staff have tried picture books/magazine with her but due to resident's poor vision, these do not interest here. Staff will try to provide colored towels/socks/clothing for resident rather than just the white towels for folding. Will also see about having her listen to music while in her room. However, there was no root cause analysis of the fall to determine if the interventions implemented were appropriate. - 8/30/18, at 11:30 a.m. Resident was sitting in the assisted dining room. She was seen attempting to stand up and turn to leave the table. She lost her balance and fell to her hands and knees then she rolled over onto her butt. Root cause attempting to self transfer, lost balance and fell. Interventions: staff sat with resident at lunch to provide one to one. There was no documented root cause analysis of the fall to determine appropriate interventions to implement.	2 830		

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2 830	Continued From page 21	2 830		

-8/30/18 at 2:45 p.m. Resident found sitting in her room by bathroom door. Root cause: confused mental status. There was no documented root cause analysis of the fall to determine appropriate interventions to implement.
-8/31/18, at 11:40 a.m., IDT team reviews fall from 8/30/18. Talked with therapy and they will be trying the weighted blanket today (repeat of weighted blanket). Resident will also be put on a walking program. Will try having resident listen to music while she is in her room (repeat of music in room). Will talk with family about what kind of music she likes. Resident will also be placed on every 15 minute checks. Team has also discussed trying lavender spray/soap to help with the impulsivity in resident. However, there was no root cause analysis of the fall to determine if the interventions implemented were appropriate.
-9/16/18, at 10:30 a.m. Resident self transferred and fell. She was walking between furniture, lost her balance grabbed/held onto chair located on both sides of her and lowered self to floor. Root cause: confusion. Intervention: provide distraction and activities.
-9/17/18, at 9:57 a.m. IDT review fall on 9/16/18. Interventions were documented as reviewed with no changes at this time. There was no documented root cause analysis of the fall to determine appropriate interventions to implement.

During interview on 10/25/18, at 10:55 a.m., Registered nurse (RN)-B stated R30's fall interventions were having a room located near the nurse station, hip protectors, assist of one walking, get involved activities as folding clothes, go for walks, have snack or cup of coffee, chocolate milk. RN-B stated regarding the weighted blanket, I know R30 used the weighted blanket, but I have not herd how the weighted blanket worked out.

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2 830	Continued From page 22	2 830		

During interview on 10/25/18, at 11:07 a.m., nursing assistant (NA)-G stated R30's fall interventions were try to make sure safe, walker in front of her, keep occupied with laundry, puzzles, coloring. Toilet every two hours and make sure her bed is at the lower level.

During interview on 10/25/18, at 11:09 a.m. NA-H stated R30's fall interventions were keep R30 in the front busy folding laundry, puzzles, take for walk, toilet, sometimes will nap and color. R30 likes to sit and have coffee and cookies. I know activity staff will spend one on one time with her too.

During interview on 10/25/18, at 1:33 p.m., the director of nursing (DON) confirmed R30's care plan and the date interventions were implemented. The DON confirmed the falls for 6/23/18, and stated there was no documentation for root cause analysis of the falls and no new interventions implemented. The DON stated for the falls on 6/24/18, at 9:00 a.m. and 9:30 a.m. there was no documented root cause for each fall to determine an intervention. DON stated for the IDT note dated 6/25/18, had no documented root cause analysis of the falls occurring on 6/23/18, and 6/24/18, to determine appropriate interventions to implement. The DON stated for the IDT review on 6/28/18, the root cause of the fall on 6/27/18 was impulsiveness. DON confirmed the sensory blanket and weighted blanket were not on R30's care plan. DON and RN-B (who joined during the interview) stated they could not answer if the sensory blanket and the weighted blanket was implemented by therapy or not. The administrator (who joined during the interview) stated she did not see the sensory blanket documented in an activity note.

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2 830	Continued From page 23 Don confirmed there was no documented root cause and intervention implemented for the fall on 7/2/18, at 9:30 a.m. The DON confirmed the IDT team did not review the falls on 7/9/18, at 3:00 p.m. and on 8/14/18, at 10:30 a.m. to determine root cause analysis and an appropriate intervention to reduce falls from recurring. The DON stated for the fall on 8/29/18, at 4:40 a.m., there was no documentation by staff to show what other interventions were tried with R30 during the night besides toileting. The DON confirmed the intervention of have R30 listen to music while in room was not documented in R30's care plan. DON confirmed use of lavender spray/soap was not on R30's care plan. Don stated the root cause of the falls on 8/30/18 was self-transferring. DON confirmed R30's care plan lacked to include staff provide 1:1 frequently or involve her in many activities. During the interview with the DON and RN-B, the DON and RN-B confirmed the use of a weighted blanket form therapy continued to be mentioned as an intervention, but there was no documentation on R30's care plan regarding use of. The DON contacted therapy during the interview and informed therapy (T)-C stated therapy received the weighted blanket but did not utilize the blanket as realized the blanket would be a tripping hazard. T-C stated therapy ordered the weighted blanket on 7/11/18 and received the weighted blanket on 7/17/18. The Don and RN-B confirmed they did not know the information from therapy regarding the weighted blanket prior to interview with surveyor. DON stated sometimes the IDT team writes will try interventions and they do not work. DON confirmed there was no documentation in R30's notes regarding interventions tried and if the interventions were successful or failed.	2 830		

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2 830	Continued From page 24	2 830		

During the interview with the DON, on 10/25/18, at 2:17 p.m., the activity director (AD)-A stated there is a sensory blanket available in the activity corner and a sensory binder available in R30's room. The DON stated the she did not see the sensory blanket on R30's care plan.

During interview on 10/25/18, at 3:37 p.m., the DON stated R30's resident included a note that read resident has been placed off 15 minute checks. DON stated 15 minute check were documented for the month of 9/18, but prior to that there was no documentation in R30's record 15 minute checks were being implemented as indicated for the intervention added on 6/24/18. The documented sheets provided by the DON showed 15 minute checks started being documented on 8/31/8 at 12:00 a.m. and ended on 9/21/8, at 11:45 p.m. The sheets lacked full documentation of the 15 minutes checks being consistently implemented. The Don stated the facility system was staff on floor to do report immediately following a fall to determine the root cause analysis and implement an intervention. A copy of the report goes to the administrator and I. We review the falls at the IDT meeting every a.m. in our stand up meeting. We talk about interventions put in place and the IDT determines what more can we do for the person falling. DON stated the IDT agrees with what is documented on the sheet for interventions by the staff and if there was a change in interventions it would be documented in the IDT note.

The facility policy Fall Risk, dated 11/28/10, indicated Policy: the nursing staff, in conjunction with the primary care provider, consultant pharmacist, therapy staff, and others , will seek to identify and document resident risk factors for falls. Procedure: 8. The staff and primary care

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2 830	Continued From page 25	2 830		

provider will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.

The facility policy Accident and Incident Investigation, dated 11/28/10, indicated Procedure: 13. Implement preventive measures as appropriate.

R15 had been interviewed on 10/22/18, at 4:25 p.m. regarding her stay at the facility and the care received. During the interview, R15 reported several falls, but was unsure of when the falls had occurred. R15 said perhaps it had been two months. When questioned about the reasons for the falls, R15 admitted to having some weakness and had gotten up without calling for help. R15 stated an understanding of her risk for future falls if she would continue to get up unattended. Despite this understanding, R15 said about getting up without staff assistance, "I shouldn't but I will." When asked what staff had done to keep her safe from falls, she was unable to say.

According to an interview on 10/24/18, 9:37 a.m. with nursing assistant (NA)-B, R15 was able to stand and transfer quite well and one staff person could easily assist her using a gait belt with a walker. NA-B said that staff try to keep R15 "up front so she can be supervised but she likes to be in her room to watch TV." NA-B was unsure about other interventions for safety but said she personally, walks by her room often.

The clinical nurse manager, licensed practical nurse (LPN)-B was interviewed on 10/24/18, at 1:29 p.m. about what was being done to keep R15 safe. LPN-B said they give R15 a call-light and remind her to use it, but says, "I think she

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2 830	Continued From page 26 just forgets to use it." Then LPN-B said, "when she is determined to do something she is going to do it." When asked if the nurses do a root cause analysis to determine why resident fell, LPN-B said this would be done at the interdisciplinary team (IDT) meeting and the results of that finding would be put in a meeting note. LPN-B also stated that they "check on R15 when they walk by" but was not able to substantiate a frequency of checks. When asked to review the resident's record for updated information on any interventions initiated, LPN-B said that the resident had a self-locking wheel-chair, but was unable to locate that information on the resident's care plan, notes or remember when this had been initiated. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could provide education on how to assess incidents to determine root cause and direct staff to implement interventions that address the root cause in order to ensure residents are safe. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be	2 945		11/28/18

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2 945	Continued From page 27 unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a dignified dining experience for 4 of 4 residents (R25, R39, R40, R202) observed during an evening meal. Findings include: R25's quarterly Minimum Data Set (MDS) dated 9/19/18, indicated R25's cognitive skills for daily decision-making were severely impaired. The MDS further indicated for eating R25 required limited assistance from one staff. R25's care plan dated 9/10/18, indicated R25 was independent with eating, and at times needed encouragement to eat. R39's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R39 had no speech, rarely/never made self-understood and rarely/never understood others. The MDS further indicated R39's cognitive skills for daily decision-making were severely impaired and for	2 945	Corrected	

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2 945	Continued From page 28	2 945		

eating required extensive assistance from one staff. R39's care plan dated 9/17/15, indicated R39 required total assistance with meals and was at risk for aspiration.

R40's admission Minimum Data set dated 10/4/18, indicated cognitive skills for daily decision-making were severely impaired. The MDS further indicated for eating R40 required extensive assistance from one staff. R40's care plan dated 10/25/18, directed staff to provide total feeding and to feed R40 slowly. The care plan also indicated R40 had a history of dysphagia (difficulty swallowing) with mild pocketing of food and R40 would eat in the assisted dining room for help and observation during meals.

During the dinner observation on 10/22/18, at 5:37 p.m. R25 sat alone at a table adjacent to the table where R39, R40, and R202 sat in there wheelchairs. Nursing assistant (NA)-C sat next to R39, clinical nurse manager registered nurse (RN)-B stood next to R40 while giving her bites of food, and NA-D sat next to R202 and was giving him bites. At 5:42 p.m., RN-B walked away from helping R40 to eat and R40 made no attempt to feed herself.

At 5:43 p.m., NA-C stopped feeding R39, sanitized his hands, walked over to R25's table, kneeled next to her, cut up her peaches, and encouraged her to take a bite. R25 had been attempting to eat her soup, however, was not able to get the spoon all the way into the bowel an no help was provided.

At 5:43 p.m., NA-D stood up and provided R40 with a bite of food, then sat back down to give R202 a bite of food. At 5:44 p.m., NA-D again stood up and provided a couple of bites of food to

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2 945	Continued From page 29 R40. At 5:45 p.m., NA-D sat back down and resumed feeding R202. At 5:45 p.m., NA-C returned to R39 four minutes later at 5:47 p.m. and gave her a drink. At 5:48 p.m. R25 struggled to eat her food; missing the bowel with her spoon, and attempted to cut lettuce with her spoon and no staff assistance noted. At 5:48 p.m., NA-D stopped feeding R202 and walked to the hand sink on the other side of the dining room. An unidentified aide stood next to R40 and gave her a bite of food then walked to the hand washing sink. Director of nursing (DON) then sat down next to R40. At 5:49 p.m. NA-D sat down next to R202 and resumed assisting him to eat. At 5:50 p.m. R25 continued to try and cut her lettuce with her spoon, tomato was on the floor. R25 brought her spoon to her mouth repeatedly; however, nothing was on it. Again no staff assistance noted. At 5:51 p.m. NA-C stopped feeding R39, walked over to a resident at another to table to provide verbal cues to sit down. NA-C returned to assist R39 two minutes later at 5:53 p.m. At 5:52 p.m. NA-D stopped assisting R202, and walked over to R25. NA-D cut up the lettuce on R25's plate. DON asked R202 if he was done eating; R202 responded "no" however, there was no staff at the table to assist him until 5:55 p.m. when NA-D returned to the table. At 6:01 p.m. NA-C stopped assisting R39 and walked away from the table and left the dining room.R39 was not provided assistance again until	2 945		

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nine minutes later when NA-D returned to help her.

During an interview on 10/22/18, at 6:16 p.m. NA-C stated R25 required variable amounts of assistance during meals from supervision to total assist. NA-C indicated it wasn't "ok" or dignified to get up and leave a resident to assist another resident during the meal; however sometimes the need arises like when a resident is attempting a self-transfer. NA-C further indicated there was enough staff in the dining room to assist and provide a dignified dining experience to all of the residents who required staff assistance to eat.

During an interview on 10/22/18, at 6:22 p.m. NA-E indicated it was not dignified to standup while assisting residents to eat and/or walk away from a residents while assisting them to eat.

During an interview on 10/25/18, at 8:48 a.m. DON stated NA's should stay seated next to the resident they are assisting to eat throughout the meal to provide a dignified dining experience.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review procedures for assisting residents with eating during meal time. The DON/designee could determine if there is a sufficient number of staff available during meal times in order to provide and ensure all residents are assisted with eating in a dignified manner and implement changes as necessary. The DON/designee could then provide re-education pertaining to dignity with dining to staff and develop an auditing system as part of quality assurance activities to ensure ongoing compliance.
TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sanitization of an individualized glucometer for 1 of 1 resident (R45), observed to have a blood sugar check and nebulizer machine equipment for 1 of 1 residents (R23), observed to be administered medication via a nebulizer. In addition, the facility failed to establish an on-going infection prevention program including comprehensive analysis and interpretation of data to identify and respond to possible patterns of infection. Findings include: GLUCOMETER: During observation on 10/23/18, at 3:03 p.m., registered nurse (RN)-C was observed to check R45's blood sugar using an individual glucometer. RN-C applied gloves, wiped the outside of the glucometer with a Super Sani-cloth wipe and laid the glucometer on a Kleenex to air dry. RN-C stated the glucometer had to dry for two minutes after cleansing the machine with the Super Sani-cloth wipe. After allowing the glucometer to air dry, the glucometer was placed in a plastic bag with insulin pens for R45, which was stored in the medication cart. Observation of the Super Sani-cloth wipe container with RN-C identified the label on the container directed allow treated	21375	Corrected	11/28/18

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surface to remain wet for a full two minutes. Let air dry. RN-C stated (in regards to the glucometer surface having to be wet for two minutes), I do not know about that, but I wiped it off pretty good. The glucometer was soaked.

The facility policy Disinfecting Glucometer, effective date 5/15/18, read Procedure: 1. Wipe all surfaces of glucometer with a Super Sani-cloth to clean the glucometer 2. Throw the wipe away 3. Per manufacturer, wipe surfaces of glucometer again to ensure the disinfection process is completed. 4. Allow glucometer to air dry for two minutes

On 10/24/18, at 2:47 p.m., observation of the Super Sani-cloth wipe container with the director of nursing (DON), the DON confirmed what the container label read for disinfecting and what the facility policy read . The DON stated I am going to have to change our policy.

NEBULIZER EQUIPMENT:
On 10/23/18, at 3:27 p.m., RN-D walked into R23's room to place a vial of liquid medication into a nebulizer machine medication cup. The nebulizer equipment was observed to be all together and there was visible liquid/moisture in the nebulizer cup where the medication would be placed. When asked if the nebulizer equipment had been cleaned after the last use, RN-D replied it does not look like it. RN-C stated he did not know what the facility policy was for cleaning the nebulizer equipment after each use. RN-C stated he did not know if the nursing assistants cleaned the equipment at bedtime or if the resident cleaned the equipment.

On 10/24/18, at 2:47 p.m., DON stated staff were to clean the nebulizer equipment after each use

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with warm water and let air dry on a clean surface.

The facility policy Nebulizer Use, dated 11/28/10, directed 8. The mask, applicator is changed weekly and cleaned at the end of the shift in warm soapy water, rinse and air dry on a paper towel. 9. Rinse nebulizer jar after each use.

INFECTION PREVENTION PROGRAM:
During an interview on 10/24/18, 12:55 p.m. registered nurse (RN)-A, the nurse responsible for the facility Infection Prevention program, stated that she gains information about the facility infections by attending report each work day and then writes that information in a log book and places a mark on a facility map. She also stated that at times she has a "lot on her plate" and so she makes a note and puts it on her bulletin board to remind her to complete the work later--this could be a day to several days later. When asked about documentation related to on-going analysis of things such as trends in types of infection, spread or frequency of infections and so on, she said that they might talk about it at their weekly interdisciplinary team meeting (IDT). She also said that while in IDT they would discuss the type of germs associated with any current infections, or in response to a possible spread of infection, they might decide to do an audit of care, and then come up with a response plan. For instance, she stated that she had done hand-washing audits and a "lot of training" on hand washing and perineal care (cleaning of the urogenital region) when she noticed more urinary tract infections one month. When asked about documentation of these IDT discussions related to infection prevention or response to identified concerns, RN-A said that she was unsure if anyone did this. She added that

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someone might write an IDT note in a resident's chart if they had an infection, but she did not believe anyone took notes related to their facility infection plan during IDT meetings. When asked about how she communicates an infection concern or plan from the IDT meeting to the facility staff, she thought this would be done by the unit clinical manager.

On 10/25/18, 8:56 a.m. a record review of the facility infection log was completed. While the record did show a monthly listing of resident infections, the log did not include documentation showing analysis of the collected data that could be used by the facility to identify such things as associated or causative factors including breaks in infection control practices, educational needs, increased or altered risks related to internal or external factors. Furthermore, the record did not include documentation of actions taken within the facility in response to identified infections. The record failed to show evidence the facility was actively looking for correlations, trends or patterns of infection within the facility.

Following the record review, RN-A was interviewed again on 10/25/18, at 9:15 a.m. and verified that the facility did not have documentation of any analysis or a response to the data from the monthly infection log. At that time RN-A said, "there isn't really...we don't really do that."

On 10/25/18, 9:20 a.m. the director of nursing (DON) was interviewed about expectations related to the facility infection prevention plan. When asked about their practices related to the tracking and analyzing portion of their plan, DON said that it was an expectation of the infection prevention nurse to track all infections and

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anything done in response to noted problems, such as audits. DON was unaware of any documentation in the facility where they may show evidence of their work related to analysis, planning or work towards preventing future outbreaks of infection. DON did say that currently the facility is not showing any trends but was unable to show evidence of written data analysis that supports this belief.

Records were requested to show evidence of on-going analysis and interpretation of infection data that was collected and any response to that information. A provided document titled Quality Assurance Performance Improvement, April 1st, 2018 through June 30th, 2018, 2nd quarter provided the following information: the number of acute illnesses, how many were acquired within the facility and how many were urinary tract infections. No other types of infection were delineated except for a statement related to a case of Norovirus in April. Below the quantified list, a list of bacterial organisms was included without any information associating the bacterium to the infections listed. The document does not include any information related to what was done in response to the listed infections or any plans to prevent future infections. No month to month analysis is noted for trending purposes. The facility also provided a document titled "Quality Assurance and Performance Improvement Meeting Minutes, August 18, 2018 which included a statement saying an RN had reviewed the infections for the quarter and identified a spike in June, but no trends. No other information related to analysis, actions or plans were written in the document provided.

A request was made for evidence of any audits done related to handwashing or perineal care

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over the last three months including any retraining done in response to the audits. The request was returned with a comment that said, "annual skills fair," along with a list of attendees, but no audits were provided. Additionally, two documents titled Annual Skills Check Evaluation--CNAs (certified nursing assistants) were provided for two different nursing assistants. One Annual Skills Check document was listed as being due July 2018, with a completion date of October 1, 2018. The other was listed as being due June 2018, and completed July 7, 2018. No associated audit was provided.

Policies related to the facility infection prevention program were requested. A portion of a policy titled Infection Control Program with a footnote stating a date of 2010 was provided (sections one, two and six). The document included the following statements:
--"The facility establishes a program under which it ...investigates, controls, and prevents infections in the facility"
--"communicates the findings from data collection to the nursing home and directs changes in practice based on identified trends, government infection control advisories and other factors"

SUGGESTED METHOD OF CORRECTION:
The director of nursing could in-service all staff on the need to follow infection control practices to eliminate the spread of infection from resident to resident, also visitors and staff.

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

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21620	Continued From page 37	21620		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 open vials of mantoux solution had a date open and 5 of 5 residents (R202, R203, R204, R49 and R205) had received medication from this vial. Also the facility failed to ensure an insulin pen alerted for a change in direction for 1 of 1 resident (R24) observed to be administered insulin. Finding include: NO DATE OPEN MANTOUX VIAL: On 10/23/18, at 11:03 a.m., observation of the facility medication storage room with trained medication aide (TMA)-A identified an open vial of mantoux solution had no date opened indicated. The stock number for the mantoux solution was 318159 and had been received on 5/25/18. The following residents had received mantoux solution administration from the stock number 318159: R202 had a first step tuberculin sensitivity test (TST) administered on 10/18/18. R203 had a first step TST administered on 10/19/18. R204 had a first step TST administered on 10/22/18. R49 had a first step TST administered on 10/05/18. R205 had a first step TST administered on 10/09/18.	21620	Corrected.	11/28/18

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During interview on 10/23/18, at 11:37 a.m., the director of nursing (DON) confirmed the mantoux vial had no date opened indicated. DON stated we would dispose of the mantoux solution.

LABEL:
R24 was administered insulin on 10/24/18, at 7:37 a.m., by registered nurse (RN)-C who had been observed to administer 30 units of Lantus SoloStar insulin to R24 via an insulin pen. The label on the insulin pen read 25 units subcutaneously every a.m. RN-C stated the medication administration record (MAR) read give 30 units every a.m. RN-C confirmed there was no indication on the insulin pen there was a change in orders for the amount of insulin to be administered. RN-C stated I never go by the label.

R24's current physician orders identified an order dated 10/15/18, to give 30 units insulin glargine (Lantus) one time a day. R24's MAR, dated for the month of 10/18, identified the insulin was being given as ordered.

During interview on 10/15/18, at 1:19 p.m., the DON was asked what should be done when the label of the medication does not match the dose being instructed to be given on the medication administration record, and there was no indication on the medication container the order had been changed. DON stated she would expect the nurse to go check the physician order in the resident chart and verify the most current order of insulin to be given. DON stated we do have direction change stickers as well.

The facility policy Medication Storage in the facility, dated 10/1/11, indicated Policy:

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21620	Continued From page 39 Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The facility policy Direction Change-labels, dated 10/24/18, indicated Procedure: 1. When an order changes and medication is still available, a directions changed, refer to chart stick will be applied to the packaging. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the	21630		11/28/18

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21630	Continued From page 40 death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure individual resident destruction of medications for non-controlled substances. This had the potential to affect several residents who had discarded medications. Findings include: During interview on 10/23/18, at 11:03 a.m., trained medication aide (TMA)-A stated the director of nursing (DON) was the person who destroyed medications. During interview on 10/23/18, at 3:20 p.m., the director of nursing (DON) stated I and another nurse destroy medications by placing them into an RX buster (drug disposal system). We highlight the name of the drug listed on a Pharmaceutical Waste sheet and if the name of the drug is not on the list, we write the name of the drug on the sheet. DON stated the facility started the process of destroying medications this way in June 2018. When asked if there was record for each individual resident medication	21630	corrected	

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destruction for non-controlled medications, the DON stated no, we only highlight the name of the drugs we are destroying on the sheets.

The instructions on the pharmaceutical Waste sheet read RN (registered nurse)/LPN (licensed practical nurse) highlights the name of the medication placed in the pharmaceutical waste for disposal. Medications need to be highlighted once. There is space provided to add the name of any medication not already listed on the form. Keep this form with the waste container. Provide a copy of the form to the Clean Harbor representative requesting a waste pick-up.

The facility policy Medication Waste process, dated 6/26/18, indicated medication disposal into blue drum will take place on a monthly basis and as needed. All unopened, fully dispensed cards can be sent back to pharmacy for reimbursement. Put medications to be disposed of on the shelf in the white basket. For nicotine and Coumadin, wrappers for these medications need to be disposed of as well and can be put on the shelf with medications to dispose of. DON or designee will complete this. Log for medications is kept in the DON office. Highlight medications that are being disposed of, if not on the list, write them in. When drum is full, DON will log into web site for EPA ID number.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could development and implement policies and procedures to destroy unused portions of other prescription drugs. The DON or designee could educate licensed staff on these policy and procedures. The DON or designee could then monitor the appropriate staff for adherence to the policies and procedures.

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21630	Continued From page 42 TIME FRAME FOR CORRECTION: Twenty One (21) days.	21630		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a dignified dining experience for 4 of 4 residents (R25, R39, R40, R202) observed during an evening meal. Findings include: R25's quarterly Minimum Data Set (MDS) dated 9/19/18, indicated R25's cognitive skills for daily decision-making were severely impaired. The MDS further indicated for eating R25 required limited assistance from one staff. R25's care plan dated 9/10/18, indicated R25 was independent with eating, and at times needed encouragement to eat. R39's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R39 had no speech, rarely/never made self-understood and rarely/never understood others. The MDS further indicated R39's cognitive skills for daily decision-making were severely impaired and for eating required extensive assistance from one	21805	Corrected	11/28/18

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staff. R39's care plan dated 9/17/15, indicated R39 required total assistance with meals and was at risk for aspiration.

R40's admission Minimum Data set dated 10/4/18, indicated cognitive skills for daily decision-making were severely impaired. The MDS further indicated for eating R40 required extensive assistance from one staff. R40's care plan dated 10/25/18, directed staff to provide total feeding and to feed R40 slowly. The care plan also indicated R40 had a history of dysphagia (difficulty swallowing) with mild pocketing of food and R40 would eat in the assisted dining room for help and observation during meals.

During the dinner observation on 10/22/18, at 5:37 p.m. R25 sat alone at a table adjacent to the table where R39, R40, and R202 sat in there wheelchairs. Nursing assistant (NA)-C sat next to R39, clinical nurse manager registered nurse (RN)-B stood next to R40 while giving her bites of food, and NA-D sat next to R202 and was giving him bites. At 5:42 p.m., RN-B walked away from helping R40 to eat and R40 made no attempt to feed herself.

At 5:43 p.m., NA-C stopped feeding R39, sanitized his hands, walked over to R25's table, kneeled next to her, cut up her peaches, and encouraged her to take a bite. R25 had been attempting to eat her soup, however, was not able to get the spoon all the way into the bowel an no help was provided.

At 5:43 p.m., NA-D stood up and provided R40 with a bite of food, then sat back down to give R202 a bite of food. At 5:44 p.m., NA-D again stood up and provided a couple of bites of food to R40. At 5:45 p.m., NA-D sat back down and

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21805	Continued From page 44 resumed feeding R202. At 5:45 p.m., NA-C returned to R39 four minutes later at 5:47 p.m. and gave her a drink. At 5:48 p.m. R25 struggled to eat her food; missing the bowel with her spoon, and attempted to cut lettuce with her spoon and no staff assistance noted. At 5:48 p.m., NA-D stopped feeding R202 and walked to the hand sink on the other side of the dining room. An unidentified aide stood next to R40 and gave her a bite of food then walked to the hand washing sink. Director of nursing (DON) then sat down next to R40. At 5:49 p.m. NA-D sat down next to R202 and resumed assisting him to eat. At 5:50 p.m. R25 continued to try and cut her lettuce with her spoon, tomato was on the floor. R25 brought her spoon to her mouth repeatedly; however, nothing was on it. Again no staff assistance noted. At 5:51 p.m. NA-C stopped feeding R39, walked over to a resident at another to table to provide verbal cues to sit down. NA-C returned to assist R39 two minutes later at 5:53 p.m. At 5:52 p.m. NA-D stopped assisting R202, and walked over to R25. NA-D cut up the lettuce on R25's plate. DON asked R202 if he was done eating; R202 responded "no" however, there was no staff at the table to assist him until 5:55 p.m. when NA-D returned to the table. At 6:01 p.m. NA-C stopped assisting R39 and walked away from the table and left the dining room.R39 was not provided assistance again until nine minutes later when NA-D returned to help	21805		

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21805	Continued From page 45 her. During an interview on 10/22/18, at 6:16 p.m. NA-C stated R25 required variable amounts of assistance during meals from supervision to total assist. NA-C indicated it wasn't "ok" or dignified to get up and leave a resident to assist another resident during the meal; however sometimes the need arises like when a resident is attempting a self-transfer. NA-C further indicated there was enough staff in the dining room to assist and provide a dignified dining experience to all of the residents who required staff assistance to eat. During an interview on 10/22/18, at 6:22 p.m. NA-E indicated it was not dignified to standup while assisting residents to eat and/or walk away from a residents while assisting them to eat. During an interview on 10/25/18, at 8:48 a.m. DON stated NA's should stay seated next to the resident they are assisting to eat throughout the meal to provide a dignified dining experience. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the need to promote dignity for all residents in the facility and complete audits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members.	21830		11/28/18

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(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section

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21830	Continued From page 47 whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the	21830		

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	00103	A. BUILDING: ____ B. WING ____	C 10/26/2018

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21830	Continued From page 48 participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure choice of arise time and bedtime for 2 of 2 residents (R18 and R24) and failed to ensure choice of preferred consistency of liquids for 1 of 1 resident (R15), reviewed for choices. Findings include: R18's quarterly Minimum Data Set (MDS) an assessment, dated 8/29/18, indicated R18 was cognitively intact and required one assist with dressing. During interview on 10/22/18, at 7:12 p.m., R18 stated he does not get to go to bed at night when he wants to. R18 stated he would like to lay down right after supper. R18 said between 6:30 p.m. and 7:00 p.m. would be the ideal time to go to bed. During observation on 10/23/18, at 2:50 p.m., R18 was in bed watching T.V. R18's sleep document, dated 8/29/18, indicated what time do you usually go to bed. Between 9 to 10 p.m. R18's current care plan indicated R18 needed one staff assist for dressing. The care plan lacked to include the time R18 preferred to go to bed. During interview on 10/24/18, at 1:31 p.m.,	21830	Corrected	

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nursing assistant (NA)-G stated she did not know what time R18 preferred to go to bed at night.

R24's significant change MDS, dated 9/19/18, indicated R24 was cognitively intact and required one assist with dressing.

During interview on 10/22/18, at 4:50 p.m., R24 stated I like to go to bed at 9:00 p.m. and would like to get up at 5:00 a.m. I do not like to argue with staff when they chose to get me up and put me to bed. It depends on who is working. One staff member will get me up at 5:00 a.m., but if that person is not working, I have to stay in bed until 6:00 a.m.

During observation on 10/24/18, at 7:10 a.m., R24 was dressed and seated in her wheelchair in her room watching T.V.

R24's sleep document, dated 9/18/18, indicated what time do you usually go to bed was 9 p.m. and what time do you like to wake up in the morning was 4 a.m. to 5 a.m.

R24's current care plan indicated R24 needed one staff assist for dressing. The care plan lacked to include the time R24 preferred to arise and go to bed.

During interview on 10/25/18, at 10:59 a.m., registered nurse (RN)-B stated the choice of time arise and time to go to bed was asked on admission on the facility sleep assessment. RN-B confirmed the time of bedtime and the time of arise identified on the sleep assessments could not be viewed by the nursing assistants. RN-B stated R18's and R24's care plan lacked to include the time they prefer to arise and go to bed.

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During interview on 10/25/18, at 1:21 p.m., the director of nursing (DON) stated she would expect the times identified on the sleep assessment for time arise and time of bed be carried over to the resident care plan.

A policy for choices was requested, but not provided.

R15's record, included a history of aspiration pneumonia but has a cognitive score of 14 out of 15 indicating only a slight cognitive loss.

During an interview on 10/22/18, 4:17 p.m. R15 stated that she didn't like the thickened liquids that were provided to prevent aspiration because they were "hard to drink" and did not quench her thirst. During that interview, R15 indicated an awareness of her risks of choking and possible aspiration pneumonia from consuming thin liquids, but voiced a willingness to take that risk when she feels thirsty.

A dismissal summary from R15's Mayo medical provider on 1/29/18- noted R15 has had several bouts with aspiration pneumonia with septic shock; however, a note written 7/16/18, by a Mayo Physician's Assistant said, "seen per resident request to progress to regular diet with regular liquids. ST [speech therapy] would like repeat swallow study. Order provided."

Swallow evaluation results dated 8/9/18, are as follows: "Moderate aspiration of nectar with spontaneous cough. No penetration or aspiration of honey or applesauce. Impression: moderate aspiration of nectar with spontaneous cough. The medical record does not show any change in recommendations for the resident in relation to

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21830	Continued From page 51 her fluid consistency following this evaluation. On 1/31/18, Speech Therapy had recommended providing "honey thick liquids only", but had indicated on 7/3/18, that ice cubes made from water thickened to the appropriate consistency could be provided. On 10/24/18, at 9:24 a.m. R15 was observed to be at the breakfast table with a glass of juice so thick it was sticking in clumps to the side of the glass. This was not consumed by the resident. No ice was seen. According to an interview on 10/24/18, at 9:37 a.m. with nursing assistant (NA)- B, said that R15 had asked for thin liquids but NA-B tells her that staff are only allowed to give what is listed on the care plan. NA-B said that R15 seemed to understand her risk of aspiration and then said "[R15] doesn't like lukewarm fluids" and so NA-B makes a habit of getting water from the drinking fountain so it is "nice and cold." NA-B stated that to her knowledge, R15 could not have ice cubes. 10/24/18, 10:26 a.m. activities director showed ice cubes made of thickened fluids that are available to resident and confirmed that R15 does prefer chilled beverages to be quite cold. On 10/24/18, 11:01 a.m. R15 was observed sitting in the day room with glass of thickened water that appeared thicker than a honey consistency, it was clumped and sticking to the edge of the glass. NA-A said in passing, "she [thickened water] is pudding thick." R15 said, "it's really thick, I don't like it," but attempted to drink it. Because of the thickness it did not flow well to her mouth. R15 made a face and said, "I don't like the taste of this" and did not drink any more of it.	21830		

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21830	Continued From page 52 During an interview, 10/24/18, at 11:06 a.m. NA-A stated that R15 is to receive "pudding thick" fluids. When asked how staff know what thickness R15 should receive, NA-A replied, "because I have worked here a long time." 10/24/18, at 11:33 a.m. R15 was observed in the dining room with juice that is pudding consistency. No ice was seen. 10/24/18, at 11:12 a.m. speech therapist (SLP)was interviewed about R15's thickened liquids. SLP said R15 had not been on the case load for a while but knew there were no new recommendations for R15 and she should receive honey thick liquids and could have ice cubes made from the same honey thick liquids. SLP also stated that they had done training for all staff in the facility within the last month and posted information throughout the facility on how to correctly thicken liquids. These posters were observed as posted. When interviewed on 10/24/18, at 1:29 p.m. the clinical manager, licensed practical nurse (LPN)-B said she was unaware that R15 did not like the ordered honey thickened liquids. LPN-B stated that the information about providing thickened liquids was on R15's care plan and was also listed on the nursing assistant care sheets. LPN-B confirmed that ice cubes made of thickened water were available for R15 to make the liquids more palatable and LPN-B stated assurance that the nursing assistants were aware they could use them. When informed that a nursing assistant had given R15 pudding thick fluids, LPN-B reviewed the care sheet and again confirmed that the correct physician order for honey thick liquids was on the sheet and that all	21830		

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21830	Continued From page 53 nursing assistants are to refer to the care sheet in order to provide cares as planned. According to an interview on 10/25/18, 9:34 a.m. the director of nursing (DON) was not aware that R15 had expressed her dislike of thickened liquids to any staff person. When asked about the protocol should a resident disagree with recommendations made for diet or altered fluid consistency, DON said they would educate the resident and if needed, would get ST involved. Should a resident continue to disagree with recommendations, the facility would offer a "shared risk agreement" to show the person understands their risk, but prefers not to follow the recommendation. DON stated that R15 had such an agreement in the past, but she is unsure if she has one currently. DON also stated a belief that R15 and nurses know that such an agreement can be completed if requested. 10/25/18, 11:39 a.m. R15 was observed in the dining room with cocoa thick enough to mound up on a spoon--pudding thick. R15's current physician orders indicated her fluid order is "honey thick." R15's care sheet was reviewed and had not indicate that ice-cubes of thickened liquids can be used. Policy for thickened liquids asked for and none received. SUGGESTED METHOD OF CORRECTION: director of nursing or designee could educate facility staff on a residents right for self-determination and the impact on psychosocial health. The education could include	21830		

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21830	Continued From page 54 when and how to initiate the facility "shared risk agreement" with residents who choose not to follow healthcare recommendations. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21830		