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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MJKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **02/05/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **52** (L18)
13.Total Certified Beds **52** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date:
Brenda Fischer, Asst Program Mgr — 02/11/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 02/11/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(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
01/11/2019
(L33)

DETERMINATION APPROVAL

Electronically delivered
February 11, 2019

Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, MN 56273

RE: Project Number S5360032 and H5360017

Dear Administrator:

On December 18, 2018, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 26, 2019.

This was based on the deficiencies cited by this Department for a standard survey completed on November 29, 2018 that included an investigation of complaint number H5360017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 5, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 29, 2018. We have determined, based on our visit, that your facility has corrected as of January 21, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 17, 2019 be rescinded as of January 21, 2019. (42 CFR 488.417 (b))

In our letter of December 18, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2019, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 21, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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. The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal

rights.

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 11, 2019

CMS Certification Number (CCN): 245360

Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, MN 56273

Dear Administrator:

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

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

Effective January 21, 2019 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MJKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00314

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(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

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(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **11/29/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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A. In Compliance With
Program Requirements
Compliance Based On:
___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: (L12)

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	52			
(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:
Bruce Melchert, HFE NE II — 01/01/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 01/11/2019 (L20)

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

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__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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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
11/01/1986
(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 December 18, 2018

Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, MN 56273

RE: Project Number S5360032 and H5360017

Dear Administrator:

On November 29, 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 November 29, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5360017. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

- State Monitoring effective December 23, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 17, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Living Community Of New London will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 29, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 11/26/18 through 11/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/26/18 to 11/29/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. In addition, at the time of the survey, an investigation of complaint #H5360017 was completed and found to be substantiated with a deficiency cited at F677. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		1/21/19

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

Electronically Signed | 12/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 1	F 550		

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 subpart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified bathing routine for 1 of 1 residents (R15) who expressed feelings of "stressed" over the facility bathing process. In addition the facility failed to provide hygiene needs to enhance dignity for 2 of 3 residents (R3 and R34) who were dependent on staff for their activities of daily living. Findings include: R15's quarterly MDS dated 8/31/18, indicated R15 was cognitively intact and received assistance with dressing and bathing. R15's care plan revised on 9/20/18, indicated R15 required assistance with bathing related to rheumatoid arthritis, and directed the staff to provide staff assistance to complete the bathing process. On 11/28/18, at 11:17 a.m. nursing assistant (NA)-J stated R15 had her bath changed to Wednesday as this was a day when there was a consistent bath aide. NA-J stated this had been changed over a month ago and the time frame has improved. On 11/28/18, at 1:10 p.m. R15 expressed satisfaction with the bath she had received on today's date and felt it was a positive experience. R15 stated she had been informed she took "too long" for a bath, however, expressed she was unable to think how to shorten this process as there were tasks which needed to be completed, such as application of callous pads, lotions, and bandages. R15 stated getting a bath weekly was enough for her but different staff members, as well as the "head one" , had told her anything	F 550	R15's bathing preference was honored and continues to be honored. Information was given on resident rights. All staff will be educated regarding resident rights. R3's shirt was changed. R34's shirt was corrected and laundry was made aware of the situation. Daily checklists for laundry department are being completed to ensure all clothing is labeled correctly. All residents will be reminded on the location of resident rights. All laundry staff will be trained on ensuring labels are placed inside the clothing correctly. All staff will review the policy regarding resident rights. Random audits of 10% of the resident population will be conducted weekly x 4, biweekly x 2 then monthly ongoing to ensure compliance as determined by the QA committee. This audit will include ensuring residents are aware they have rights, as ensuring clothing is clean and labeled correctly. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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	245360	A. BUILDING _____ B. WING _____	C 11/29/2018

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over an hour is "too long." R15 stated this made her feel "stressed out" and she did not look forward to her bath day because of told it takes too long to complete her cares. This made her feel, unwanted and not important.

On 11/29/18, at 1:38 p.m. the social services designee (SSD)-A stated R15's bathing routine had required more than two hours of staff time because R15 was particular with her cares. A conference were held with R15, family member, facility staff and the Ombudsman to determine what could be done to streamline R15's bathing process. SSD-A stated R15 was capable of doing things independently and at the conference the recommendation was for R15 to come up with a list of things she could do independently to decrease the bath times from two hours. SSD-A described R15 as being "unrealistic", to needed to make changes to something "more reasonable". SSD-A stated R15 had not been willing to work with them, even though SSD-A approached her on several occasions. The Ombudsman suggested R15 make a list of things she could complete independently to shorten the bathing process, but R15 has not created this list. When she asked R15 about the list which would "Curb down the bath times down from the two hours to something more reasonable" R15 "would not work with her." SSD-A stated this recommendation was made by the Ombudsman and resident was not receptive of this.

A review of Resident Progress Notes dated 10/31/18, narrative note of 10/31/18, completed by SSD-A indicated the care coordinator was informed of R15's "unrealistic expectations for bathing." Additonal notes completed on 11/9/18, indicated SSD-A explained to R15 to stream line

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her bathing time as it was "far [sic] to other residents that are waiting for a bath."

On 11/29/18, at 3:20 p.m. RN-A stated although R15's interaction with others varied, she found it most beneficial to allow resident time to vocalize her feelings ("vent") and listen to her concerns. RN-A stated being told your request for bathing routine was unrealistic would "make you feel like they didn't have time for you."

R3's quarterly Minimum Data Set (MDS) dated 8/4/18, indicated R3 had a significant cognitive impairment and received total assistance to complete dressing and grooming. The MDS identified medical diagnoses included dementia and a progressive neurological disorder.

R3's care plan revised on 11/20/18 identified R3 required total assistance of staff for dressing and grooming and directed staff to provide with total assistance to complete activities of dressing. The care plan also indicated R3 had severe cognitive impairment and directed staff to anticipate needs.

On 11/26/18, at 2:03 p.m. R3 was observed as she was being propelled from the day room by nursing assistant (NA)-K and had an area that was tan colored of moist food debris on her blouse. The area was approximately four inches in width and seven inches in height on the left side, covering her breast area of the blouse. The staff proceeded with R3 to her room. At 3:35 p.m. R3 was in her room on her bed wearing the same soiled blouse, with visible dried food debris. At 5:01 p.m. R3 was in the dining room, awaiting evening meal still wearing the same soiled

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blouse. At 6:16 p.m. R3 was in the day room, holding her lap robe up to her chest. At 6:40 p.m. R3 was assisted to her room by NA-I to get ready for bed. NA-I stated R3's blouse had dried food on it and should have been changed when they initially notice the area, for the resident's dignity.

On 11/28/18, at 12:29 p.m. registered nurse (RN)-A stated R3 was very conscientious of her appearance and would be bothered having on soiled clothing. RN-A stated soiled clothing should be changed when initially noted as this was a concern for resident dignity.

R34's quarterly Minimum Data Set (MDS) dated 10/14/18, identified R34 had severe cognitive impairment and required extensive assistance with his dressing and personal hygiene.

On 11/26/18, at 3:35 p.m. R34 was seated in a high-back wheelchair in the commons area of the nursing home attempting to self propel his wheelchair to the dining room. R34 had a blue colored, polo-style shirt on which displayed a visible white colored label on the back of the shirt, facing outwards. The white colored label had R34's name spelled out in black, typed font.

During subsequent observation on 11/26/18, at 6:09 p.m. R34 continued to have a blue colored shirt on which continued to outwardly display R34's name spelled out on the white label. R34 could not provide a legible responses when questioned about his clothing being labeled.

On 11/26/18, at 6:11 p.m. nursing assistant (NA)-G observed R34's labeled shirt with the

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F 550	Continued From page 6 surveyor. NA-G stated the shirt was on correctly and not inside out, then added she did not think the name label "should be on the outside." NA-G explained the shirt should be labeled on the inside, but reiterated his name "doesn't need to be out there [on the outside]." During interview on 11/28/18, at 9:25 a.m. NA-A stated R34 should not have his name visible on the outside of his clothing as it was "a personal thing" and "a dignity thing." When interviewed on 11/28/18, at 11:26 a.m. registered nurse (RN)-B stated she was not sure why R34's clothing would be labeled with his name on the outside; however, added it should have been labeled on the inside. The facility policy Quality of Life-Dignity, revised 10/09, identified each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy also indicates being treated with dignity means the resident will be assisted in maintain and enhancing his or her self-esteem and self-worth.	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in	F 552		1/21/19

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F 552	Continued From page 7 advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform interested family members about a medical treatment that included a physician's order and subsequent administration of an as-needed intra-muscular (IM) medication to control behaviors for 1 of 1 residents (R13) who had dementia and dependent upon staff for activities of daily living. Findings include: R13's Resident Face Sheet dated 11/26/18, included diagnoses of dementia and Alzheimer's disease with late onset. The Face Sheet also identified family members (FM)-C and FM-D as responsible party and emergency contacts. R13's CAA for cognitive loss/dementia dated 8/29/18, indicated severe impairment and R13 resided on secure unit for safety. The CAA for falls dated 8/29/18, indicated R13 had poor judgement and safety awareness and wandered. The CAA further indicated R13 had impaired mobility and used a four-wheeled walker, and required extensive assistance of one staff for all transfers, toileting, dressing, and personal hygiene. R13's admission CAAs did not identify aggressive behaviors.	F 552	Hydroxyzine IM order was discontinued on 12-6-18. All of said resident's medications are given orally. Orders were reviewed with family on 12-4-18 and family is updated with any order changes. All licensed staff will review the Comprehensive Assessment and Care Planning Policy to ensure residents/resident representatives are involved with the care planning/treatment process. All residents have the potential to be affected. All licensed staff will review the Comprehensive Assessment and Care Planning Policy to ensure that residents/resident representatives are involved with the care planning/treatment process. Medications will be reviewed with resident/resident representative upon admission/re admission. All residents will be reminded of the location of the resident rights. Medications/Care Plan will be reviewed at routine care conferences and upon admit/readmit. Random audit of 10% of the resident population or resident representatives will be interviewed to ensure they feel they	

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F 552	Continued From page 8 A Meeker Memorial Hospital Behavioral Health progress note dated 11/6/18 indicated R13 was admitted on 10/23/18 to 11/6/18 for behaviors, in the context of her dementia. R13 was discharged back to the nursing home on 11/6/18. The Meeker Memorial Hospital Medication Reconciliation - Discharge/Transfer report dated 11/5/18, included an order for hydroxyzine (antihistamine medication used for sedation in treatment of anxiety) intramuscularly (IM) injection, every four hours as needed, for agitation and aggression. R13's current physician's orders dated 11/12/18 included hydroxyzine HCl solution 50 mg/ml (milligrams per milliliter) 1 ml intramuscularly for agitation/aggression, delusions, hallucination, calling out, hitting, etc. every 4 hours PRN (as needed). R13's care plan revised 11/15/18, did not identify a problem with R13's behavior or aggressions, also there was no indication that an intra-muscular medication had been ordered by a physician. A nursing progress by registered nurse (RN)-E dated 11/18/18 indicated: "[FM-D] had visited at the top of the shift. upon his departure, resident wandered hallway w/o [without] walker. Writer brought walker to resident and resident threw walker at writer. Resident had been friendly to other residents up until 4:00 p.m. Resident had been verbally abuse to staff all shift, and around 4, resident stood up and walked across the dining area to threaten CNA [certified nursing assistant]. [R13] said "Get off your horse and get the hell out of here." There was a table between resident and	F 552	have their right to be involved and informed in the treatment plan. This will be audited weekly x 4, biweekly x2 then monthly ongoing as determined by the QA committee. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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CNA at the time. At that time all residents who were able to self transfer left the dining room and to go to their rooms. [R13] was asked by writer to go to the toilet, at that time resident showed her fist and yelled "I pay for this place and I can do whatever the hell I want." Writer requested and received assistance of male CNA who is known to have good reputation with the resident to distract her while writer administered 1 ml (milliliter) of ordered PRN [as needed] hydroxyzine [an anti-histamine medication, indicated for itching, but may also be used short term to treat anxiety] IM [intra-muscularly]."

During interview at 2:39 p.m. on 11/28/18, with RN-E about the 11/18/18 incident, she acknowledged she utilized R13's order for as needed hydroxyzine and administered the medication after R13 became "riled up" on the unit. RN-E stated the incident happened on a Sunday (11/18/18), later in the afternoon. RN-E stated she did not know why R13 was agitated that day, and could not recall if during the incident if she was trying to administer medications to R13 or only talking to R13 to help calm her down. RN-E stated R13 was yelling and hollering and "I just didn't know what else to do." RN-E stated R13 had a physician's order to administer the medication and to hopefully help calm her, so she administered the injection.

When interviewed at 8:50 a.m. on 11/28/18, licensed practical nurse (LPN)-A stated R13 returned from the hospital stay "with an active order for IM hydroxyzine." LPN-A stated she recalled the order because there was a fax with R13's doctor to clarify the order. LPN-A stated the order was "1 ml (milliliter) IM every four hours for agitation, aggression, delusions,

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hallucinations, calling out and hitting." LPN-A stated R13's physician order was still current.

During phone interview at 6:20 p.m. on 11/12/18, family member (FM)-C talked about R13 having received a medication "by way of injection" because of her behaviors. FM-C stated she was upset because she felt the facility did not give her a heads up about this medication order when R13 returned from her hospital stay. FM-C stated she thought the order for injection was requested by facility staff since her return, and added "that is part of the problem, it seems there is a lot we just don't know." FM-C stated they had a care conference after R13 got back from the hospital, but "nothing was said about the IM (intra muscular injection) as being an option for treatment." FM-C stated she was also upset having learned about the use of the injection "a couple days after it happened." FM-C said (R13) took medications by mouth, and stated " questioned why the staff used the injection." FM-C stated the facility should "please let me know what you are thinking!" FM-C stated after learning [R13] got the injection, "I cried, just knowing she got it, I cried."

A nursing progress note dated 11/15/18, indicated a care conference was held following R13's return from hospitalization. In the progress note social services designee (SSD) indicated medications were reviewed, and family questioned "times for some meds." SSD's note did not elaborate on which medications were reviewed, including the intra muscular, as-needed medication and others that were prescribed during R13's in-patient hospitalization and subsequent return to the nursing home.

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When interviewed at 7:13 p.m. on 11/28/18, family member (FM)-D stated she attended R13's care conference after R13 returned from the behavior health unit at the hospital. FM-D stated during the meeting, she did not learn that a injection, would be used for R13's behaviors. FM-D stated "I had never heard such a thing discussed during the care conference." She learned R13 had received an "IM injection" from FM-C, who stated RN-B called "a couple days after" R13 got the injection and questioned, "What is up with that?" FM-D stated the medication "was not discussed at the care conference" and would like to know what was happening with R13.

When interviewed on 11/29/18 at 1:46 p.m., registered nurse (RN)-B stated during care conferences, medications are reviewed, but that specific routes for medications (the way a medication is taken: oral, inhaled. injected) "was typically not discussed." RN-B stated she thought the family requested a list of the medications R13 was on after she came back from the in-patient stay. The care conference with R13's family "went on for two hours" and recalled the family's insistence medication "not be changed" not that R13 had returned. RN-B stated since R13's return from the behavioral unit, the "IM medication" prescribed for R13 "should have been talked about, but likely just got missed." RN-B acknowledged family was upset that R13 had received an injection medication due to behaviors, and also that R13's family felt they were unaware of this route of medication for R13. RN-B stated he knew R13's family "would be unhappy about that."

A policy regarding participation in resident care

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F 552	Continued From page 12 planning was requested, but none was provided.	F 552		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine personal grooming and cleanliness for 2 of 3 residents (R34 and R3) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. Findings include: R34's quarterly Minimum Data Set (MDS) dated 10/14/18, identified R34 had severe cognitive impairment, required extensive assistance with personal hygiene, and displayed no rejection of care behaviors. R34's care plan dated 11/2/18, identified R34 required assistance with ADLs and listed several interventions to help him meet his needs including, "Ext A 1 [extensive assist of one] with dressing, personal hygiene, and bathing as condition requires." During observation on 11/26/18, at 3:13 p.m. R34 was seated in a recliner chair in his room watching television. R34 had visibly long fingernails on both hands with several nails being approximately several millimeters in length and having a dark substance present underneath the	F 677	R34's nails were cleaned and filed immediately. R3's soiled shirt was changed. All nursing staff will review the ADL Care Policy. All residents have the potential to be affected. All nursing staff will review the ADL Care Policy to ensure proper ADL cares are being completed for our residents. Random audits of 10% of the resident population weekly x4, biweekly x2 then monthly ongoing or as determined by the QA Committee to ensure proper ADL cares are being completed. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis.	1/21/19

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nail towards the side of the nail fold. R34 was questioned about his nails; however, did not provide a legible response.

On 11/27/18, at 8:56 a.m. and 11/28/18, at 9:14 a.m. subsequent observations were made of R34 who continued to have visibly long fingernails with the same, dark colored substance present underneath several of the nails towards the nail fold.

When interviewed on 11/28/18, at 9:25 a.m. nursing assistant (NA)-A stated R34 required "pretty much extensive" assistance to complete his ADLs and personal hygiene. NA-A explained nail care should be completed during a residents' scheduled bath, and if they refused, it should be documented in the charting. NA-A observed R34's fingernails and stated "they need to be done," and "cleaned really good" as R34 often scratches his arms.

On 11/28/18, at 11:26 a.m. registered nurse (RN)-B was interviewed and explained personal grooming, including nail care, should be completed with routine cares and on a residents' scheduled bath day. RN-B reviewed R34's medical record and stated he last received a bath on 11/27/18, and provided a flow sheet used to track completed baths to the surveyor for review.

The provided Weekly Bath Body Audit flow sheet dated 11/27/18, listed each resident's name whose bath was completed along with additional columns to record their weight and other things including a column labeled, "Nails Trimmed or filed." R34 was recorded as having a bath completed; however, the column for R34's nails was left blank and not completed. There was no

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recorded evidence to demonstrate if R34 had received any nail care, nor if R34 had been offered nail care and declined.

RN-B stated there was "nothing recorded" on the flow sheet and added nail care should be completed to reduce infection risks and help "prevent skin issues like scratching himself."

An undated Care of Fingernails and Toenails policy was provided which listed objectives including to prevent spread of infection and prevent injury. A procedure to complete nail which included, "Document appropriately" was listed.

R3's quarterly MDS dated 8/4/18, indicated R3 had a significant cognitive impairment and received total assistance to complete dressing and grooming. Further, R3's care plan revised on 11/20/18, identified R3 required total assistance of staff for dressing and grooming and directed staff to provide total assistance to complete dressing.

On 11/26/18, at 2:03 p.m. R3 was observed being propelled from the commons area by NA-K. R3 had an area of tan colored, moist food debris on her blouse covering an area of approximately four inches in width and seven inches in height covering the left breast area. The staff proceeded to wheel R3 to her room. Later on 11/26/18, at 3:35 p.m. (over an hour later) R3 was resting on her bed, however, continued to have the same soiled blouse on with the dried food debris as observed earlier.

During subsequent observation on 11/26/18, at 5:01 p.m. R3 was seated in the dining room

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F 677	Continued From page 15 waiting for the evening meal service. R3 continued to have the same soiled clothing on. At 6:40 p.m. R3 was assisted to her room by NA-I for evening cares. NA-I stated R3's shirt had visible, dried food on it and added it should have been changed when it first became soiled. NA-I expressed this should be done because R3 is unable to do this for herself and is dependent upon us to meet those needs. On 11/28/18, at 12:29 p.m. registered nurse (RN)-A was interviewed and indicated R3 was very conscientious of her appearance and soiled clothing should be changed timely.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to complete a comprehensive activities assessment for 5 of 5 residents (R3, R15, R26, R10, and R33) who were were reviewed due to observation of decreased participation in activities. Findings include:	F 679	The said residents' activity assessments are completed. A full house audit was conducted and a schedule was created to complete all activity assessments by 1-21-19. All new admits will have the activity assessment completed on admit.	1/21/19

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F 679	Continued From page 16 R3's quarterly Minimum Data Set (MDS) dated 8/4/18, indicated R3 had a significant cognitive impairment and received total assistance to complete activities of daily living including mobility. The MDS identified medical diagnoses included dementia, a progressive neurological disorder, anxiety, and depression. R3's significant change MDS completed on 5/4/18 indicated participation in the following activities were very important: Religious activities, Go outside. Additionally, activities identified as being somewhat important included: Music, news, group activities, and favorite activities. The Care Area Assessment (CAA) did not trigger for the significant change assessment. R3's care plan revised on 11/13/18 indicated R3 "loves to read", reads some magazines in her room, and likes country western music. Staff are directed to invite and encourage activity participation. A review of R3's medical record lacked a current comprehensive activity assessment. On 11/26/18, at 2:03 p.m. R3 was observed in the day room, positioned so she was facing towards the window. R3 was the only resident looking out the window. On 11/27/18, at 9:19 a.m. R3 was observed seated in the dayroom in front of the television with three other residents. The television channel is tuned into a television show which is describing the use of razor wire use to keep individuals contained. After a period of approximately 10 minutes, Wellness Director (WD)-A observed the television program and changed the channels to	F 679	Wellness Director educated on the Activity Assessment policy. Moving forward, all Activity Assessments will be reviewed with the MDS schedule. Random audits of 10% of the resident population will be completed weekly x4, biweekly x2 then monthly ongoing to ensure compliance with proper activity assessments. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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a western show.

On 11/27/18 at 1:42 p.m. R3 was observed to be resting on her bed in her room with the room lights off, room was quiet, without music or television playing.

On 11/29/18, at 11:30 a.m. R3 was seated in the lobby while the wellness program was going on,. R3 was observed to be sitting in the circle, however eyes were closed and resident's head was positioned down and to the left. Although resident was seated in the circle, the two staff members leading the activity made no attempts to engage her in the process.

On 11/28/18, at 12:04 p.m. R3's activity participation was reviewed for the month of November with activity assistant (AA)-A. A review of the activity record identified R3 participated in watching television on a daily basis, however, aside from this, had only four other entries documented for the month of November. Of the four entries, two of the entries indicated R3 had refused participation in church or communion service. R3 was identified as having participated in "Special Activities" on 11/5/18 and 11/10/18, however, upon reviewing the November activity calendar a "Special Event" was not listed on the calendar. There was no indication of what other events R3 participated in.

On 11/28/18, at 12:34 p.m. the Wellness Director (WD)-A reviewed the activity attendance sheets for from November to September 2018. WD-A stated R3's November attendance sheet identified on 11/5/18 R3 participated in the voting process and on 11/10/18 R3 participated in the monthly birthday party. Upon further review of

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calendars, it was identified voting process did not occur on 11/5/18 and WD-A was unsure what special event R3 participated in. WD-A stated she does do one to one visits with resident, however, was unable to demonstrate this with documentation. Additionally, WD-A stated activity staff frequently invited resident to activities and resident has refused, however, acknowledged the activity record does not reflect this. R3's October activity record identified that resident had participated in church/communion on two occasions, quiz on one occasions, and games/Jingo/bowling on two occasions, and a special party on one occasion. R3's September activity record indicated R3 participated in church/communion on one occasion, games/Jingo/bowling on three occasions, and T. ball on one occasion. R3 was also noted to particle in exercised on two occasions and bible study on one occasion. WD-A stated R3's last comprehensive activity assessment was completed in 2015, when R3 was more independent with leisure activities. They have not updated her assessment since even though R3 has declined and unable to make decisions. Upon review of the R3's care plan with WD-A, WD-A reviewed interventions which included "enjoys reading" and "likes music". WD-A stated although these interventions are listed, they have not been individualized for R3. WD-A stated with completion of a comprehensive activity assessment staff would determine residents preference and allow for development of an individualized plan of care.

R3's last assessment was completed in 2015 when R3 was independent with leisure activities with improved cognition. The assessment was not updated to reflect R3's current level of

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dependency nor was there any indication of what specific music or reading R3's enjoyed as part of an individualized assessment.

R15's quarterly MDS dated 8/31/18, indicated R15 was cognitively intact and was noted to be independent with mobility. R15's medical diagnoses as identified by the MDS i included: heart failure, hypertension (high blood pressure), cardiomyopathy (disease where the heart becomes enlarged), chronic pain syndrome, osteoarthritis, rheumatoid arthritis (chronic inflammatory disease which can affect more than just joints), auto immune disorder (disease which can cause inflammation in joints, skin, and other organs), anxiety and depression. R15's significant change MDS completed on 2/28/18 indicated it was very important for R13 to participate in group activities and religious activities. The activities area did not trigger for the CAA..

R15's care plan revised on 9/20/18, identified R15 enjoyed independent activites, as well as activity programs and wellness class. The care plan directed staff to invite and encourage activity participation. There was no indication a comprehensive assessment was completed.

R15's activity attendance sheets for November of 2018 identified R15 participated in church and communion services on five occasions, special entertainment on two occasions, trivia on two occasions, kitchen activities on four occasions, games/jingo/bowling on five occasions, and bingo on four occasions. R15 participated in exercises on 16 occasions in the month of November and watched television on a daily basis. The attendance record did have a notation which

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indicated R15 did not wish to participate in afternoon activities.

R15's activity for October of 2018 identified R15 in church or communion services on three occasions, special entertainment on two occasions, trivia on one occasions, kitchen activities on three occasions, games/jingo/bowling on two occasions, and bingo on six occasions. R15 participated in exercises on 20 occasions in the month of October and watched television on a daily basis. R15 participated in four outings in October and attended one movie. A chaplain visit was identified on four occasions. A notation was made on the attendance sheet which identified "No night activities."

R15's activity for September of 2018 identified R15 in church or communion services on five occasions, special entertainment on one occasions, trivia on one occasions, games/jingo/bowling on five occasions, and bingo on five occasions. R15 participated in exercises on 21 occasions and watched television on a daily basis. R15 participated in one outings in October and spent time outside on two occasions. A chaplain visit was identified on four occasions, in addition to staff visits on two occasions.

On 11/28/18, at 12:34 p.m. WD-A reviewed R15's faciltiy record and indicated a comprehensive activity assessment had not been completed for R15. WD-A stated a comprehensive activity assessment was important to enable to develop a person-centered plan of care.

Although R15 was participating in activites, there

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was no indication a comprehensive assessment was completed to identify R15's specific interests, or preferences to assist in supporting her physical, mental, and psychosocial well-being to atain their highest level of function.

R26's admission Minimum Data Set (MDS) dated 6/26/18, identified books, magazines, listening to music, and religious services as being very important to R26. The MDS indicated R26 had moderate cognitive impairment and was dependent on staff. R26's care area assessment (CAA) for activities did not trigger for further assessment.

There was no indication a comprehensive activity assessment that included R26's past and current activity preferences.

R26's care plan dated 10/22/18, identified R26 liked music, re-runs on television especially westerns and game show and visits with family. The care plan identified interventions to provide R26 with calendar of events, invite and encourage activity participation., assist with the television, encourage social opportunities with friends in the facility.

During observation on 11/27/18, between 9:00 a.m. and 10:12 a.m. R26 was lying in bed with her eyes open. The television was not on and there was no music playing in R26's room. At 2:23 p.m. an activity "Kitchen Day" was going on in the main dining room with residents eating wild rice sandwiches and conversing with staff and other residents. During this time R26 was lying in bed with her eyes open looking at the ceiling, with no television or music on. Staff made no attempts to assist or encourage R26 to attend this activity.

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When interviewed on 11/27/18, at 3:19 p.m. wellness coach (WC)-A stated current events had just ended, and activities were done for the day at 3:30 p.m. She stated R26 usually attend bingo and kitchen day but was unsure if R26 attended the activity today.

During observation on 11/27/18, at 3:22 p.m. R26 was seated on edge of bed with her hands in her lap looking at the room curtain. R26 was not engaged in any activity in her room, the room was quiet.

When interviewed on 11/28/18, at 12:20 p.m. wellness director (WD)-A stated there was no comprehensive activity assessments in R26's medical record. A comprehensive activity assessment would be done to ensure the residents activity goals were met, resident preferences to ensure the residents life was as good as it could be in the facility. R26 occasionally attended group activities which included bingo, current events and kitchen day. WD-A had not invited R26 to current events and kitchen day because R26 was sleeping when she made her rounds.

R26's activity attendance sheet dated November 2018, identified R26 attended large groups for games three days and kitchen day three times. She attended small group attendance and TV every day with independent activities of reading.

Although R26 was participating in some activites, there was no indication a comprehensive assessment was completed to identify R26's specific interests, or preferences to assist in supporting her physical, mental, and psychosocial

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well-being to atain their highest level of function.

R33's quarterly minimum data set (MDS) dated 10/12/18, indicated R33 was cognitively intact, but was extensively dependent on staff for transferring and mobility. She had diagnoses of depression and schizoaffective disorder. The Activities Care Area Assessment had not been triggered on the Admission MDS dated 4/4/18. However, the MDS indicated that R33 felt it was very important to be involved with music, animals, news, and going outside.

During interview on 11/26/18, 3:25 p.m. R33 shared she stays in her room, watches TV, and reads books and magazines. She participated in activities when she first came to the facility but in the past three months she "just doesn't feel like I fit in". The other residents are much older. R33 stated she was offered books and magazines, but no one has asked her why she was spending time her room. R33 had never told the facility about her feels of not fitting in.

On 11/27/18, 9:04 a.m. R33 was observed propelling her wheel chair (wc) up and down the hallway near her room. R33 stated, she wanted to get better so she could get out of the facility. At 2:10 p.m., R33 was in the dining room, participating in a food activity social, of crackers, cheese and other dips. R33 was engaged in a group discussion, talking with other residents and smiling.

R33's care plan dated 4/9/18, she likes Bingo, being with people, and wants to join in activities.

Review of R33's Therapeutic recreation

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Department progress notes identified the following:

-10/12/18 resident attends group activities as she wishes. Likes wellness class daily and other activities. Went on as outing recently and enjoyed it. Is active in Resident Council.
- 9/7/18 resident invited to a free concert for an outing at the local winery and enjoyed the evening.
-7/5/2018 resident has just returned from the hospital. Needs rest times now. Has enjoyed most group activities before surgery. Staff will continue to invite to activities when she is feeling better.

During interview on 11/29/18, 1:45 p.m. Activities Director (AD) stated she she had only been in the positron for a month and a half. It has been brought to her attention, that several residents including R33 lacked an activity assessments and was unsure why these were never completed.

Although R33 attended some activities, there was no indication a comprehensive activities assessment was completed that identified R33's recreational, social preferences or specific interests to assist in supporting her physical, mental, and psychosocial well-being to atain her highest level of function.

R10's significant change minimum data set (MDS) dated 8/20/18, indicated R10 was severely cognitively impaired, and was extensively dependent on 1- 2 staff for all activities of daily living. The Activities Care Area Assessment had not been triggered. However, the MDS indicated that R33 felt it was very important to be involved

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with animals, religious services and going outside.

During interview on 11/26/18 2:31 p.m. R10 stated he spends much of his day in bed, watching TV and attends wellness class when staff come to get him, and he enjoys the class.

On 11/27/18, between 9:34 a.m. and 2:32 p.m., R10 was observed lying in bed, watching TV with the door closed. R10 stated the hall was too noisy and wanted the door closed so he could hear the TV.

On 11/29/18, at 11:18 a.m. R10 is lying in bed, eyes open with his television on. Two facility staff invited to a wellness activities. R10 was assisted to his Broda chair and taken to the facility's Wellness Activities and was participating with the exercise group.

R10's care plan dated 5/14/18 indicated the facility provided, spiritual care and other supports. He likes pets, enjoys visits from family and friends, country and rock music. Enjoys word find puzzles with has goals of "Will have physical needs met daily express to staff satisfaction with his room activity and Wellness Class as able."

Review of R33's medical record, there was no indication a comprehensive activity assessment, was completed to include recreational and social preferences.

During interview on 11/29/18, 1:45 p.m. Activities Director (AD) stated she she had only been in the position for a month and a half and there was no activity assessment for R10 even though he has

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F 679	Continued From page 26 been in the facility since May 2018. Although R10 attended some activities, there was no indication a comprehensive activities assessment was completed that identified R10's specific interests to assist in supporting his physical, mental, and psychosocial well-being to atain her highest level of function. A facility Wellness policy dated 2017, identified "complete a comprehensive assessment with the resident and/or resident representative to understand the resident's individual preferences on activities as related to their quality of life. To include day-to-day leisure pursuits, customary routines, and community involvement prior to admission."	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper foot support was provided to prevent feet from dangling for 1 of 8 residents (R3) who utilized a wheel chair.	F 684	R3's footrest was adjusted on 11-28-18. All nursing staff will review the Positioning Policy to ensure proper w/c positioning. A full house audit will be conducted to ensure proper w/c positioning. All nursing	1/21/19

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	245360	A. BUILDING _____ B. WING _____	C 11/29/2018

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F 684	Continued From page 27 Findings include: R3's quarterly Minimum Data Set (MDS) dated 8/4/18, indicated R3 had significant cognitive impairment and required total assistance with all mobility. The MDS identified R3 diagnoses included dementia, restless legs syndrome (a condition that causes an uncontrollable urge to move your legs, usually because of uncomfortable sensation), low back pain and abnormal posture. R3's care plan revised 11/20/18, indicated R3 required total assistance from staff for all areas of mobility related to progressive neurological disorder and dementia. The care plan directed staff to provide with assist for all aspects of mobility. The care plan indicated staff were to seek out an occupational therapy (OT) referral as needed for Broda chair positioning or positioning. On 11/26/18, at 6:16 p.m. R3 was observed sitting in her Broda wheelchair in an upright position with a calf and foot rest in place. R3 wore stockings on her feet, which pointed downward. The tips of R13's toes were approximately two inches from the foot rest, and R3's heels were about six inches off of the foot rest not being supported. During observation at 9:25 a.m. on 11/27/18, R3 was again seated in an upright position in her Broda chair, and R3's stocking feet were suspended above the foot rest at approximately 6 inches at the heels, and about 1-2 inches at the end of her toes, not being supported by the foot rest. On 11/28/18, at 9:55 a.m. R3 was observed in the	F 684	staff will review the Positioning Policy to ensure proper w/c positioning. Random audits of 10% of the resident population will be completed weekly x4, biweekly x2 then monthly ongoing to ensure compliance with positioning. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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F 684	Continued From page 28 dining room at the dining room table. R3's stocking feet dangled above the foot rest. When interviewed at this time, nursing assistant (NA)-E stated R3's foot rest was in it's usual position. NA-E stated R3 wore shoes at times, however, but had not been wearing because R3 had sore feet. NA-E stated R3 sometimes moved her feet around with the foot rest in this position. On 11/28/18, at 12:29 p.m. registered nurse (RN)-A stated R3 was fitted with the Broda wheelchair by the certified occupational therapy assistant (COTA).. On 11/28/18, at 12:51 p.m. COTA-A evaluated R3's footrest and stated it had been lowered, "but needed to be readjusted." R3's footrest was adjusted which allowed R3's feet to fully be supported by the footrest. A facility policy was requested for wheelchair positioning but was not received.	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 timely assess and document safe smoking abilities for resident	F 689	Smoking assessments have been completed for R19 and R33.	1/21/19

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F 689	Continued From page 29 safety for 2 of 2 residents (R19 and R33) who smoked. Findings include R19's admission Minimum Data Set (MDS) dated 9/19/18, indicated R19 had severe cognitive impairment and had no upper extremity limitations. When interviewed on 11/26/18, at 6:32 p.m. family member (FM)-B stated R19 smoked when away from facility about three days a week with FM-B's supervision. R19 did not have a history of burning holes in clothing or skin. During observation on 11/26/18, at 7:00 p.m., R19 was resting in bed there were no burns or burn holes seen in his clothing. R19's progress note dated 1/11/18, identified R19 was removing his nicotine patch and no longer wanted the patch as R19 was continuing to smoke. R19's medical record lacked a comprehensive assessment regarding R19's smoking abilities to ensure safe smoking. When interviewed on 11/27/18, at 3:11 p.m. licensed practical nurse (LPN)-B stated R19 had nicotine patches and would pull them off as soon as staff had walked out of the room. LPN-B suspected R19 smoked when out with his FM-B. There had not been any incidents of burned clothing or skin and the registered nurses (RN) were responsible to complete the smoking assessments on all residents who smoked.	F 689	All nursing staff will review the Smoking Policy and be educated to report to the charge nurse if they are informed that a resident is smoking. All Case Managers will be educated on ensuring safe smoking assessments are completed and will review the Smoking Policy.A full house audit of all residents that leave the campus with family/friends will be conducted to ensure that a smoking assessment is done if they are smoking while out with family/friends. Random audits of 10% of the resident population will be completed weekly x4, biweekly x2 then monthly ongoing to ensure compliance with smoking assessments. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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F 689	Continued From page 30	F 689		

When interviewed on 11/28/18, at 1:01 p.m. RN-B stated smoking assessments were completed if a resident smoked. R19 did not have a smoking assessment, and should have been completed when they knew R19 smoked. RN-B stated smoking assessments were completed to ensure resident were safe when smoking.

R33's quarterly Minimum Data (MDS) dated 10/12/18, identified R33 had intact cognition with impaired functional range of motion (ROM) on one side of her upper extremity and both sides of lower extremity.

Her care plan, updated on 11/5/18, identified she was alert and oriented, with some forgetfulness. Her Admission Baseline Care Observation dated 3/28/18 identified her nicotine dependence as a behavior concern with social services/psychosocial goals and approaches identified as her being smoke free with assistance of patch to help with her smoking sensation.

On 11/26/18, at 3:25 p.m. R33 stated she smoked at the top of the hill on the other side of the facilty's property line. Her friends always helped her get there since it was difficult for her to do this independently or brought her outside to smoke. She smoked when friends visited. She kept her cigarettes in the medication cart and asks for them when she wants to smoke. R33 states the staff give her the cigarettes when she leaves the facility. R33 has not smoked for a "couple of weeks" because no one was available to take her outside to smoke.

Review of R33's medical record lacked a comprehensive smoking assessment that

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F 689	Continued From page 31 identified R33's smoking abilities to determine if she could safely smoke independently. During interview on 11/26/18, 2:40 p.m. RN-B identified R33's had open package of menthol Marlboro cigarettes and a lighter in the top right side of a medication cart. Residents are not allowed to store cigarettes in their rooms so all cigarettes are kept secured in the medication carts. Residents were not allowed to smoke at the facility and she had never seen R33 smoke. RN-B stated R33 may leave the facility with friends and can do whatever she wants when out with friends. RN-B stated she has not given R33 any cigarettes for a "really long time". During observations of R33 on 11/26/18 at 3:25 p.m., 11/27/18 at 9:04 a.m. and 11/27/18 at 2:10 p.m. had no burn holes on her clothing and no smoke odor. During interview on 11/28/18, 8:16 a.m. Social Services Designee (SSD) stated R33 has not smoked at the facility since she arrived on 3/26/18. SSD knows she was a smoker and does not know why a smoking assessment was not completed. SSD knew R33 had cigarettes at the faciltiy but does not know where they are kept.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		1/21/19

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F 698	Continued From page 32 by: Based on observation, interview and document review, the facility failed to track fluid intake and implement dietary changes in timely manner for 1 of 1 resident (R19) on dialysis with fluid restriction and a high phosphorus level. Findings include: R19's admission Minimum Data Set (MDS) dated 9/19/18, identified R19 had severe cognitive impairment. The MDS identified a diagnosis of end-stage renal disease (ESRD) and was receiving hemodialysis. R19's High Risk Nutrition Assessment dated 10/29/18, indicated R19 had a 1500 milliliter (ml) fluid restriction related to R19's ESRD. The assessment lacked a breakdown of fluids provided by dietary at meals and what nursing would provide between meals and at medication passes. R19's care plan last revised 11/28/18, indicated R19 required hemodialysis and went to dialysis three times a week, and was on a fluid restriction of 1500 ml. The nursing assistant care guide dated 11/28/18, failed to identify any fluid restrictions. A progress note dated 9/12/18, identified R19 was on a 1500 ml fluid restriction with no water mug in his room. During observation on 11/26/18, at 5:55 p.m. a large blue mug had approximately 1000 ml's full of ice and water sitting on R19's over-bed table within reach of R19.	F 698	Both the diet order and fluid restriction monitoring were put into place during survey. A full house audit will be conducted to determine that residents on fluid restrictions have fluid intake monitoring set up also that proper diet order is being followed. All nursing staff and dietary staff will review Dietary Change and Dialysis policies. Random audits of 10% of the resident population will be completed weekly x4, biweekly x2 then monthly ongoing to ensure fluid monitoring is set up and correct diet is ordered. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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F 698	Continued From page 33	F 698		

When interviewed on 11/28/18, at 8:08 a.m. NA-E stated the nursing assistants recorded fluid intake for meals in books located in the dining room. NA-E further stated she was not sure if fluid intake outside of the dining room were recorded anywhere. NA-E was unaware R19 was on a fluid restriction.

When interviewed on 11/28/18, at 8:47 a.m. dietary aide (DA)-A stated the bottom of R19's diet slip identified the amount of fluids R19 was allowed each meal for fluid restrictions. DA-A further stated nursing staff were responsible for documenting fluid intake.

R19's undated diet slip identified "renal diet 1500 ml restriction". There was no indication of how many ml's R19 could have at each meal on the diet card.

When interviewed on 11/28/18, at 8:51 a.m. dietary director (DD) stated the fluid restriction on the bottom of R19's diet slip was the total amount of fluids R19 could consume in one day.

When interviewed on 11/28/18, at 9:05 a.m. NA-F stated stated water mugs in resident rooms were changed every shift. NA-F further stated she was not aware R19 was on a fluid restriction and provided a water mug in R19's room.

On 11/28/18, 9:10 a.m. RN-B stated R19's fluid intakes were monitored at each meal, dietary staff were responsible for tracking intake at meals and the nurses would track what fluids they gave on their shift sheets. R19's fluid restriction was not being tallied for the total daily amount of fluids consumed.

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F 698	Continued From page 34	F 698		

R19's fluid intake sheet in the electronic medical record did not include any fluid totals. There was no indication of how much fluid R19 was receiving with medication pass and at his bedside.

R19's dietary intake worksheet dated November 2018, indicated R19 consumed 180 ml to 540 ml at breakfast and dinner, three lunch meals at 360-540 ml, no other lunch meals had been recorded for the month. Previous months fluid intakes had been requested, but none were provided.

During telephone interview on 11/29/18, at 1:09 p.m. registered dietician (RD) stated R19 was on a 1500 ml fluid restriction. Typically fluid restrictions were broken out to list what a resident could have at each meal and the amount of fluid the nursing staff could use for medication passes. RD further stated the fluid restriction for R19 should have been broken out when he was first admitted to the facility and were not. It was important to accurately track R19's fluid intake so he would not become dehydrated or have fluid over load leading to complications from dialysis.

In addition, R19's nutrition report from dialysis dated 10/8/18, indicated R19's phosphorus level on 10/2/18, was 4.2 milligrams/deciliter (mg/dl) (target range 3.0-5.5 mg/dl). A Nutrition report from dialysis dated 11/20/18, indicted R19's phosphorus level was 6.3 mg/dl.

R19's Dialysis Communication Record dated 11/20/18, included and order to change R19's diet to a low phosphorus diet and included a list of high phosphorus foods to avoid which included chicken, waffles, pancakes, cheese and milk.

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F 698	Continued From page 35 During observation on 11/28/18, at 7:35 a.m. R19 was in dining room for breakfast and had a waffle with syrup, 120 ml of orange juice, 240 ml of milk, 120 ml of water , half of a banana, and scrambled eggs. R19 had consumed the waffle, 120 ml of orange juice, 240 ml of milk, 120 ml of water. R19's progress note noted dated 11/20/18, recorded as a late entry on 11/26/18, at 11:47 a.m. indicated R19 had been to dialysis, and encouraged to consume lower phosphorus intake and a phosphorus food list was sent to the facility. When interviewed on 11/28/18, at 8:51 a. m. DD stated they were notified on 11/27/18, by nursing of changes to a low phosphorus diet. Dialysis sent a list of high phosphorus foods to avoid and she was changing R19's diet in the computer system. DD stated when a diet change occurred nursing would send a communication slip to her identifying the diet change. When interviewed on 11/28/18, 9:10 a.m. RN-B stated an email had been sent on 11/26/18, to both DD and RD after RN-B received a phone call from the dietician at dialysis regarding communication sent on 11/20/18, for R19 to have low phosphorus diet. RN-B further stated diet change slips had not been used to communicate the diet change. In addition, to the email sent to the RD, RN-B spoke to RD in person on 11/27/18. R19's family member (FM)-C returned the communication record on 11/24/18, four days following the order provided by dialysis. The facility did not communicate with FM-D when a communication record was not returned to nursing staff upon R19's return from dialysis.	F 698		

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F 698	Continued From page 36 During phone interview on 11/29/18, at 1:09 p.m. RD stated DD received the diet change on 11/27/18. RD further stated an email was received on 11/27/18, at 2:05 p.m. from RN-B informing her of changes in diet for R19. RD had completed a high risk assessment on 11/28/18, and orders were supposed to be entered into the computer system as soon as they were received. Attempted telephone call to RD at dialysis on 11/29/18, at 12:03 p.m. and 01:25 p.m. and on 11/30/18 at 3:20 p.m., with no response.	F 698		
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, and implement behavior management interventions for 1 of 1 residents (R13) who exhibited escalating physical and verbal behaviors with frequent aggressions toward staff causing distress. This resulted in actual psychosocial harm for R13 who had repeated behaviors of hitting, kicking, grabbing, and use of vulgar language that required hospitalization and subsequent intramuscular (IM) medication to alleviate these unassessed, escalating behaviors. Findings include: R13's Resident Face Sheet dated 11/26/18,	F 744	Dementia/Mood/Behavior care plan was developed for R13 and reviewed with family after a comprehensive assessment was completed. This CP includes specific interventions and approaches. This information is available to all staff. All staff will be educated on the location of this information. Case Managers will review the Dementia Care/Care Planning Policies. A full house audit of resident Dx/Medications/Behaviors was conducted to determine the need for Dementia/Behavior assessments/care plans. Comprehensive assessments will	1/21/19

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F 744	Continued From page 37 included diagnoses of dementia and Alzheimer's disease with late onset. R13's admission Minimum Data Set (MDS) dated 8/29/18, indicated R13 was severely cognitively impaired, and had diagnoses including dementia and Alzheimer's disease with late onset. The MDS identified R13 had no depression, and further indicated R13 had no physical behaviors, such as hitting biting, or kicking; or verbal behaviors, such as threatening, screaming, or cursing; and no rejection of cares or wandering. R13's admission care area assessments (CAA) dated 8/29/18, for cognitive loss/dementia indicated severe impairment and R13 resided on secure unit for safety. Care area assessment for behavioral symptoms did not trigger. R13's CAA for urinary incontinence dated 8/30/18, indicated R13 was frequently incontinent of bladder since admission, was at risk for increased incontinence related to need for staff assist to find bathroom at times, and has significant cognitive impairment, diagnoses, medications. Staff assist with toileting routinely and monitor for change in continence. A Glen Oaks Pre Admission Assessment form dated 8/22/18, indicated in the section, "Comments on behavior, Treatments, infections etc: "coming from assisted living to secured memory care, wanders frequently, paranoid of new staff. Compliment her clothes, smile, direct eye contact, before cares. Needs q 2 hr (every two hours) toileting while awake. Can be aggressive when agitated." A type-written sheet, identified Tips for her caregivers caring for R13, undated, included a "Behaviors" heading and indicated: R13 does NOT like new care givers, especially younger staff, please follow to	F 744	be completed to determine specific behaviors and interventions to determine if the interventions are effective. A schedule was created to ensure all residents with Dementia/Behaviors have a proper care plan/assessment. These will be reviewed with the routine assessment schedule and updated/changed in time as needed. Random audits of 10% of the resident population will be completed weekly x4, biweekly x2 then monthly ongoing to ensure residents with Dementia/Behaviors have the proper Care plan in place and that staff are aware of where to find the information. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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decrease behaviors: "1. When coming to assist her with anything, always get down to eye level and say hello and compliment her on how she looks or ask how she is doing first. SMILE. 1. Don't ask her if she wants to do something as this is too difficult for her to process and she will often refuse, Just lead her by the hand toward the task [bathroom] or say 'come with me' or say 'it's time to.'"

R13's care plan, revised 11/15/18, did not identify or address R13's behaviors or aggressions as a separate care area, but behaviors were addressed under "toileting." The care plan directed if R13 refuses or becomes combative, as evidenced by seeking out other with intent to harm, ramming other with walker, striking out, kicking, pinching, scratching, grabbing at staff and raising fists with cares/activities, to leave R13 in a safe situation and re-approach after a few minutes. If unsuccessful, try alternate care giver, and then attempt to re-approach when resident appears to be approachable. If continues to be resistive or combative, change activity, and attempt to involve her in activity. If continues to refuse and be combative with staff, contact outside nursing staff or family for ideas on how to approach the situation. Under the care area of sensory/ cognition/ communication, R13's care plans directed staff to monitor for change in behavior related to agitation, aggression, refusals, depression and weepiness. The area identified in the care plan were generic and not individualized to help reduce or alleviate R13's aggressive behaviors. Even though the nursing home had a Tip Sheet for Caregiver from R13's previous facility which identified specific interventions for her behavior, these were not identified on her care plan.

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During observation on 11/26/18, at 5:01 p.m. R13 was seated in the dining room at the start of the evening meal, where nursing assistant (NA)-B asked R13 what she wanted to eat and drink. R13 was served a meat sandwich, bowl of vegetable soup,baked cinnamon apples and glass of cranberry juice to drink. R13 intermittently ate bites of her sandwich, and was reminded and encouraged to eat and drink, but took only bites. At 5:25 p.m. family member (FM)-E came onto the unit and sat near R13 and also encouraged R13 to eat. Following the meal R13 ambulated with a 4-wheeled walker (4WW) from the dining room and sat in a recliner in her room and visited with FM-E.

During observation on 11/27/18, between 9:45 a.m. and 10:23 a.m., registered nurse (RN)-C was on the memory care unit assisting and supervising residents in the dining area. R13 was ambulating the hallways on both sides of the dining area. At 9:48 am RN-C asked R13 if she needed to use the bathroom to which R13 responded, "I don't have to go." At 9:54 a.m. RN-C intercepted R13 in the hallway and questioned her again about toileting and R13 responded by saying, "Why do I need to go in there?" RN-C stated, "Clean underwear." R13 paused her walking, then continued on down the short hallway on the unit. When R13 turned at hallway's end and came back RN-C suggested "Let's go in the bathroom, where are you going?" R13 replied,"Where I want to" and tells the staff to "kiss my ass" and R13 continued to ambulate. RN-C again asked R13 to toilet at 10:23 a.m. without success.

During observation on 11/28/18, at 9:07 a.m.

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R13 was seated in a chair at the table with two other residents at breakfast. R13 was finished eating and was looking about the room and observing staff and other residents. At 9:11 a.m. R13 stood up without her walker and was walked around the dining room, touching the table tops as she navigated the area without her walker. NA-D got R13's walker and placed it in front of R13 and asked her is she needed to use the bathroom. R13 ignored NA-D's question, took the walker and ambulated out of the dining area, down the hall. A few minutes later R13 parked her walker next to her and sat on the small couch in the dining area. At 10:06 a.m. while seated in the couch, NA-D approached then asked R13, as she stood up, if she needed to use the bathroom, to which R13 responded "kiss my ass" and began ambulating down the main hallway on the unit. At 10:12 a.m. NA-B met R13 near her room door as she ambulated toward her room door. NA-D asked if she could see something in her room, and once inside R13's room, NA-D pointed R13 to the bathroom, asked if she needed to go, to which R13 responded "yes" and ambulated into the bathroom and subsequently toileted.

Review of R13's progress notes from 8/29/18 to 11/28/18, identified the following:

-9/24/18 Resident tried to kick AM (morning) staff while doing her cares (R13) was easily redirected.

-9/27/18 (R13) was pacing in the hallways and tried to hit staff who were blocking the doors to get out. R13 later calmed down and has been sitting in her room watching TV

-10/2/18 R13 was aggressive with aide and pulled on the aide's arm while aide attempted to

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help another resident into a w/c (wheel chair).

-10/6/18 (R13) refused lunch d/t (due to) being agitated. R13 trying to run over staff with her walker and threatening to "kick your ass!" R13 did take her medications well.

-10/6/18 At bedtime R13 was approached by writer to take teeth out, and was swung writer reapproached R13 later and was verbally assaulted. When other staff attempted helping, R13 chased staff around until with walker while swinging it close, kicked staff in chest with trying to help resident into bed; slapped another staff that attempted to help; when told "Good night, I hope you sleep good," R13 replied "I hope you get hit by a car."

-10/7/18 Resident was hitting and punching staff, causing bruising to staff and refused personal cares when resident urinated on her bed and floor.

-10/10/18 Resident refused HS (night time) medications X 1 (one time), R13 then took it after the second attempt/ PM. Only one attempt to hit staff tonight.

-10/11/18 Resident was pleasant and allowed AM cares before breakfast. After breakfast resident became combative, refused toileting and blood pressure measurement. Res would not follow direction even after multiple approaches and staffs attempts.

-10/12/18 Writer entered R13's room at 6:45 to administer morning med, R13's mood was per usual, writer bent down to offer the spoon with pill and applesauce when R13 grabbed writers's shirt

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and forcefully tugged and whipped writer's neck around. Writer tried to release R13's grip but was unable and R13 continued. R13 pulled so hard at writer's shirt that shirt spilt down the middle at which time R13 lost grip and writer able to back away.

A progress note dated 10/12/18, indicated social service, director of nursing and nurse manager made a conference call to family member (FM)-C in regard to R13's behaviors. Nursing reviewed meds (medications) with Pharm D (pharmacist) prior to call. Medications and behaviors were discussed with FM-C. Facility is considering a behavioral health stay may be warranted with increased behaviors noted in the past few weeks, escalating today. Family came to facility to discuss option. The note indicated family member (FM)-D, FM-C and FM-E came to the facility to discuss option. Family agrees that behavioral stay may be the best solution for behaviors as no triggers were found and there was no correlation with time and/or staff. Referral faxed to behavior unit.

A nursing progress note dated 10/15/18, indicated a fax (facsimile) was sent to R13's physician. "Resident has been having escalated behaviors. Resident is refusing to toilet when soaked. Resident has been hitting, kicking, and grabbing at staff. Resident was noted to be constipated also during the past week. Family does toilet her and not let staff know. The behaviors have been escalating over the past month. Staff has questioned pain, migraines, and constipation. With family involvement, Nursing and Social Services feel the best route is to have a behavioral health stay at Litchfield. The next opening is around Tuesday. Resident has made

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comments about being scared at the facility to family. Resident has not made comments like this to staff. Staffs [sic] have been questioning migraines. Resident was noted to be holding her head. Staff does not know what to use to be done for migraines. Staff started her on Tylenol 650 mg (milligrams) PRN (as needed) at 12n (noon) and 5 p.m.; along with her scheduled Tylenol ER (extended release) BID (two times daily.) No documented behaviors this weekend."

A progress note dated 10/15/18, indicated R13's physician was okay with a behavioral health stay for R13, as long as FM-C was okay with it. R13's physician thinks FM-C had a change of heart over the weekend regarding the in-patient stay, and the physician also discussed changing R13's medications. R13's physician decided it was a lot to start messing with (R13's medications) and would not be beneficial to resident. The physician does not feel [behaviors] migraine are related.

A progress note (PN) dated 10/16/18, indicated the facility received orders for a behavioral health stay R13. FM-C contacted R13's physician and wanted to try switching medications, as FM-C "did not want to move [R13] and cause unneeded stress on her. The PN indicated R13 will start Seroquel (antipsychotic medication) 12 mg BID (twice daily) for a week, and staff will update doctor in a week.

A review of R13's medication administration record for October 2018 indicated R13 received Seroquel 12.5 mg: one dose beginning 10/16/18, and twice daily 10/17/18 through 10/23/18, a total of 15 times.

A review of the progress notes, after the initiation

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of Seroquel on 10/16/18 through 10/23/18 indicated the following:

-10/20/18 Resident was verbally abusive to staff at start of shift, medications were difficult to administer, reapproached x5. After administration resident call writer "stupid.'" At snack time an unrelated residents' spouse calmed down the resident after (R13) was yelling at both NA and RN. He said "(R13) us Norwegians can't let others see that we get angry." This was the only intervention that calmed R13 down. After the evening meal, residents were sitting on the chairs in the hallway when R13 stood up, pushed her w/c aside to took steps to punch the NA twice.

-10/21/18 Upon the start of the shift, resident appeared to be riled up. R13 was combative, swinging at nursing staff using vulgar language. R13 call a TMA (trained medication assistant) a 'bitch' and R13 was hesitant with cares.

-10/21/18 Bedtime routine went per usual, many redirections were necessary to carry out the task. R13 did strike out at staff x1.

-10/22/18 R13 was trying to ram her walker into staff while she was helping her with cares today-no further behaviors.

A progress noted dated 10/23/18, indicated FM-C and FM-D were at the facility and made the decision to have R13 get an evaluation at Meeker Memorial behavioral health. A bed hold was signed and additional paper work sent with family to Meeker.

The facility census record indicated R13 left the

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facility for an in-patient, behavioral-health hospitalization on 10/23/18, and returned to the facility on "11/6/18."

A Meeker Memorial Hospital physician's progress note dated "11/5/18," indicated R13 was at the hospital for "behaviors in the context of her dementia, was doing well and was going back to the nursing home today." A Patient Continuing Care form dated 11/5/18, indicated the nursing summary of hospitalization: "[R13] has showed a decrease in agitation. Takes medications with food (crushed) and has shown no signs of being physical. There has been no threatening of staff. UTI [urinary tract infection] was found and was treated with Ciprofloxacin [an antibiotic medication]." R13's hospital discharge notes contained no behavioral assessment or interventions. R13's record lacked evidence the facility reassessed R13 upon return to the facility.

Review of R13's progress notes from 11/6/18 to 11/28/18, identified the following:

-11/6/18 [FM-C] here till lunch, after [FM-C] left resident refused to remain at the meal and got up and wandered the halls. Resident sat in different chairs and got back up again over and over. Staff attempted to toilet but resident started swinging at them and attempted to ram her walker into staff.

-11/17/18 Resident very agitated this morning, going out of her way to grab and hit at staff, staff was able to pull away form her hitting but was unable to remove her arm from resident's grip. Resident hit staff five times, attempted to hit at staff another six times, and attempted to run staff over with her walker.

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-11/17/18 Resident not aggressive, let writer put dentures in and glasses on. Took medication easily. Nursing apprehensive about toileting, writer waited to re-approach. Family came in and toileted resident.

-11/18/18 by RN-E identified, "[R13]'s [FM-E] had visited at the top of the shift. Upon his departure, resident wandered hallway w/o [without] walker. Writer brought walker to resident and resident threw walker at writer. Resident had been friendly to other residents up until 4 p.m. Resident had been verbally abuse to staff all shift, and around 4, resident stood up and walked across the dining area to threaten CNA [certified nursing assistant]. [R13] said, "Get off your horse and get the hell out of here." There was a table between resident and CNA at the time. At that time all residents who were able to self transfer left the dining room and to go to their rooms. [R13] was asked by writer to go to the toilet, at that time resident showed her fist and yelled "I pay for this place and I can do whatever the hell I want." Writer requested and received assistance of male CNA who is known to have good reputation with the resident to distract her while writer administered 1 ml [milliliter] of ordered PRN [as needed] hydroxyzine [an anti-histamine medication, indicated for itching, but may also be used short term to treat anxiety] IM [intra-muscularly]."

R13's November 2018 Psychotropic Drug Monitoring form, which tracked R13's behaviors. The form had space to record the target behaviors, interventions and outcomes for each shift, for each day of the month. The form identified three behaviors to monitor: "Agitated," "Spitting out," and "Verbally abusive," and listed

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several, generic interventions including "re-direct, 1 on 1, toilet, give food, fluids, (and others)." The form identified the outcome to the interventions "worsened" R13's behavior or were left blank. The interventions identified were generic, and there was no indication an individualized non pharmacological interventions were developed to decrease or eliminate R13's behavioral aggression.

During interview at 6:02 p.m. on 11/26/18, FM-E acknowledged R13 "had some behaviors," but thought those behaviors were manageable. FM-E also stated he had "questions about the use of the shot" to control R13's behaviors. During the interview FM-E commented there were often new faces and staff giving care to residents on the unit and FM-E stated R13 "usually did not respond well to that."

When interviewed at 6:20 p.m. on 11/26/18, FM-C expressed numerous concerns about R13's ADLs not being done timely. FM-C said R13 did have some behaviors, and stated they occurred during toileting, and added R13 "did not do well with new staff." FM-C questioned why the facility did not have the same staff on the unit, and she and other family members discussed "numerous times" with the facility about having consistent staff work with R13. They felt this would have eliminated many behaviors exhibited by R13. FM-C stated the facility response regarding consistent staff was their fear of staff burn out, "to which I replied that is not an excuse!" FM-C stated that "should be an intervention," to have the "same, consistent staff work" with R13. FM-C said she did consent to having R13 evaluated at the behavioral unit, but was still frustrated upon R13's return to the nursing home. She started

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exhibiting the same behaviors, "nothing really changed." FM-C stated she felt frustrated with the facility because there was "no consistent approach" to caring for R13, and added "I cried" when she learned staff used IM medication when R13 got aggressive. FM-C stated they had a care conference after R13 got back from the hospital, but "nothing was said about the IM (intra muscular injection) as being an option for treatment." FM-C stated she was also upset having learned about the use of the injection "a couple days after it happened." FM-C said (R13) took medications by mouth and "questioned why the staff used the injection." FM-C stated the facility should "please let me know what you are thinking!" FM-C stated after learning [R13] got the injection, "I cried, just knowing she got it, I cried."

During interview at 2:39 p.m. on 11/28/18, RN-E acknowledged she utilized R13's order for as needed hydroxyzine and administered the medication after R13 became riled up on the unit. RN-E stated the incident happened on a Sunday, later in the afternoon. RN-E stated she did not know why R13 was agitated that day, and could not recall if during the incident if she was trying to administer medications to R13 or only talking to R13 to help calm her down. RN-E stated R13 was yelling and hollering and "I just didn't know what else to do." RN-E stated R13 had an order to use the medication to help calm her, was administered via injection. RN-E identified the IM was not really effective, and she did not know if she would give the medication again.

When interviewed at 12:51 p.m. on 11/28/18, licensed practical nurse (LPN)-C talked about R13's behavior and stated R13's negative

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behaviors occurred when staff tried to toilet R13 and stated "maybe we didn't have a good behavior management plan" for R13. LPN-C questioned the need for the in-patient hospital stay for R13, "which other may have seen differently." LPN-C stated during his shifts R13's behaviors "were manageable," with patience and a lot of re-direction. LPN-C added, "I would not think to use IM medication to control behaviors."

During interview at 1:37 p.m. on 11/28/18, RN-B summarized R13's nursing home stay. RN-B stated R13 had been in assisted living, was admitted in the locked memory care unit, began to have aggressions toward staff, especially during cares, had an adult behavior mental health stay at a hospital, then returned. RN-B stated prior to the in-patient stay, there was an attempt to change medications, but that was not successful. RN-B stated R13's behaviors "center on incontinence and refusal to allow staff to assist her." RN-B acknowledged and stated in regard to R13's behaviors, "there probably was not a comprehensive assessment" completed upon admission. RN-B stated, "[R13]'s current behavioral assessment for behavior was lacking." RN-B stated the care area assessments for cognitive loss/ dementia was "lacking" and acknowledged R13's CAA for falls and toileting contained more information addressing R13's behaviors. RN-B stated information for assessments was gathered from many sources including family, observations, and staff. RN-B showed the surveyor a "Get to know me" form where staff submitted their ideas and notes for R13's care. RN-B also referred to a type-written sheet "[R13] Tips for her caregivers," which contained very specific approaches regarding R13's behaviors, wandering, and tips for giving

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medications and toileting. RN-B acknowledged they should have added these interventions and they had not completed a comprehensive assessment. RN-B stated "there was no a specific behavior care plan" for R13.

The interview continued and RN-B stated "there were no new formal assessments" made regarding behaviors after R13 returned from the behavioral health stay. RN-B discussed the incident when R13 got an "IM" medications. RN-B stated upon return from the hospital, R13 had an order to use IM hydroxyzine for aggressive behaviors, and recalled communication with R13's doctor to clarify the orders. RN-B acknowledged the use of the IM medication given to R13 and stated since she was not present during the incident, was hard to comment on its use. RN-B stated the care plan did not specifically address use of the IM, or really detail what actions and interventions staff should take to addresses R13's behaviors. RN-B stated there was the doctor's order to use the "IM" for R13, but no protocol, steps or interventions to try first, "only re-direction and re-approach." RN-B stated she realized "the assessment is really not there." RN-B stated R13 was currently in a review period "and those assessments is what I am working on."

When interviewed at 1:06 p.m. on 11/29/18, the director of nursing (DON) stated at admission each resident was assessed, as was R13, to compile information, "assess triggers and interventions of what is working," to build the resident care plan. The DON stated assessment information was gathered from the resident themselves, staff, from family, and in the case of R13, the DON stated the facility had a history with

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that resident. The DON stated staff were trying the care planned approaches for R13, but "they were not working." The DON acknowledged R13's behaviors escalated, and the focus became making sure R13, other residents and staff were safe, and this ultimately lead to her behavioral health evaluation.

Although from R13's prior placement history, and admission to the nursing home, R13 exhibited frequent and escalating aggressions toward staff. There was no indication a comprehensive assessment of R13's behaviors was completed to identify what the behaviors were, when they occurred, with whom, the frequency, antecedents, and discussion of why behaviors occurred. There was no indication of what interventions were consistently implemented and evaluated to determine if there were effective. Prior to her admission the Glen Oaks Pre Admission Assessment form dated 8/22/18, identified specific interventions to manage R13, which included utilizing consistent staff, complimenting R13 about her dress, making eye contact but there was no indication these were consistently implement nor was there any mention of these interventions on R13's care plan. As a result R13 behaviors continued to escalate to the point of R13 was hospitalized. Upon return from her hospitalization for behaviors, the facility did not re-assess and implement any behavior interventions. The lack of re-assessment, care plan and implementing interventions caused R13 behaviors to escalate, and caused harm when R13 had to be hospitalized for behavior management, and subsequently receiving an IM medication to control her behavior.

A facility policy, Dementia - Clinical Protocol,

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F 744	Continued From page 52 revised March 2015, identified under Assessment and Recognition, the IDT (inter-disciplinary team) "will review past and current physical, functional and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications, and functional impairments." Under Cause Identification, the policy indicated, should psychiatric consult be needed to help manage behavioral issues, "the IDT will retain an active role by reviewing and implementing the consultant's recommendations, addressing issues that affect mood, cognition and function, monitoring for complications related to treatment, and evaluating progress." And in the Monitoring and Follow-Up" section, the policy directed: "The IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, etc."	F 744		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide social service assistance to navigate and resolve voiced conflicts with financial services and utilities for 2 of 2 residents (R20 and R15) who required social services involvement.	F 745	R20 has had follow up in regard to this concern. SSD gave R20 the phone number to his financial POA. SSD will continue to follow up to see if this resident would like to change POA and assist as requested. R15 was given information on services that are available in the area and	1/21/19

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F 745	Continued From page 53 Findings include: R20's annual Minimum Data Set (MDS) dated 8/2/18, identified R20 had intact cognition and no guardian or legally authorized representative. During interview on 11/26/18, at 5:48 p.m. R20 stated he was concerned about how his finances were being handled. R20 explained a gentleman in town managed his money for him; however, R20 expressed he didn't know where this gentleman was or how much money he even had left in his accounts. R20 stated this had been a concern for a "couple months" now, and staff were aware of these concerns; however, there had been no actions taken to resolve them. R20's progress note dated 11/12/18, identified R20 had a care conference with his family member (FM)-A present. A section of the note labeled, "SS [social services]," identified, " [FM-A] did discuss wanting to change resident's financial POA [power of attorney] d/t [due to] him being hard to get a hold of, discussed resident's brother calling and talking to resident's case worker as she may be able to assist in the start of this." R20's medical record was reviewed and lacked any evidence this concern had been followed up on, or any processes' initiated by the facility's social services department to start the transition of POA for R20's finances, despite concerns being raised about the POA in the care conference. On 11/28/18, at 11:41 a.m. registered nurse (RN)-A and licensed practical nurse (LPN)-A were interviewed. RN-A explained there was "a guy" who managed R20's finances who was "not	F 745	a call was placed to the county CM to see what other services may be available. Family was also contacted to update them on the concern. Assistance continues to be offered to R15 and R20. A full house audit will be conducted to determine who may be affected. This will also include an audit to collect information of residents that currently choose phone/cable services through the facility. SSD will be educated on SS role and will have a clear and concise understanding of job duties and expectations. Clear communication will be given on admission and at quarterly care conferences to ensure residents know that assistance is available through Social Services. Random audits of 10% of the resident population will be completed weekly x4, biweekly x2, then monthly ongoing to ensure residents feel they have access to Social Services assistance. In time interventions will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our QA team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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always the easiest to get a hold of." FM-A with R20 both raised this concern at their last care conference. A discussion was held regarding changing the POA, and FM-A was given information for R20's county case worker so he could contact them and start arranging a transition of POA responsibilities. RN-A expressed there had been no additional follow-up or action by the facility to help R20 transition his POA since the care conference was held on 11/12/18, to her knowledge. Further, LPN-A added the nursing home was responsible to assist the resident with issues like these, and the county should be assisting only as needed.

A telephone call was placed to FM-A on 11/28/18, however, there was no answer and no return call provided.

When interviewed on 11/28/18, at 12:24 p.m. social services designee (SSD)-A stated she had been present for R20's care conference when the concern of R20's financial management was discussed. SSD-A stated there had been "no discussion" of the money or it's whereabouts; however, R20 and FM-A expressed the financial POA was "difficult to get a hold of" and FM-A stated they wanted to look at changing POA as a result. SSD-A did not recall if R20 expressed he wanted to pursue changing POA at that time; nor had there been any further follow-up with R20 since the care conference to clarify his wishes or desires regarding his financial POA situation. SSD-A expressed this had not been done as R20 did not come directly to her and verbalize the desire to change the POA. Even though SSD-A was in R20's care conferance during this discussion, SSD-A did not assisted R20 with these changes.

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R15's quarterly MDS dated 8/31/18, indicated R15 was cognitively intact.

On 11/26/18, at 2:27 p.m. R15 expressed concern about the charges for the cost of her cable and phone bill. R15 stated the deduction was now at $61 and that took the majority of the money allowed for personal expenses per month. R15 stated she had not been charged this fee upon the initial admission to the facility and was unsure why this was implemented. R15 stated if you don't have cable you are unable to have TV. R15 was admitted to the facility to the transitional care unit (TCU) and then transferred to long term care status. R15 stated she was not aware of the charge of service when she transitioned to long term care status. R15 stated she was not aware there were other options available to decease the cost of her phone and television.

On 11/29/18, at 11:41 a.m. the administrator stated telephone and cable services were included in the care package for the transitional care unit (TCU). The administrator stated residents who reside as long term care residents may purchase cable services and telephone services. The administrator stated for those residents who do not wish to purchase these services, there are community televisions and telephone for use by residents of the facility. The administrator stated when a resident transferred from TCU to long term care services, they would be offered the choice to contract services. Upon review of R15's records, was billed following transition to long term care status. The administrator stated the monthly charge for cables services was $20, and telephone service was at a dollar a day with an additional charge of

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$0.20/minute for long distance charges.

On 11/29/18, at 1:38 p.m. SSD-A provided documentation dated 3/31/18 which was signed by R15 which indicated R15 chose to receive the services of both cable TV and telephone services upon transition to long term care status, at the identified cost. Additional documentation was provided to indicate on 11/27/18 R15 removed her cable television and telephone services. SSD-A stated she was aware R15 was on a fixed income but was unaware of any options available for fixed income residents for telephone service, or to use the facility internet guest service. SSD-A stated that she had not reviewed potential options available to resident when services were discontinued due to residents concerns with cost. SSD-A was aware R15 had a case manager through Kandiyohi County, but was unaware of other options for R15.

Although the facility has guest internet services, SSD-A was unaware of the facility capability to use a service such as Netflix or Hulu with the wireless Internet. Additionally, SSD-A was unaware of the capability to allow communication with Internet calls SSD-A was unaware or many any attempts to seek out other services or programs residents with low income could utilize, for entertainment and communication with their families.

A facility policy titled Provision of Social Services copyrighted 2017, identified medically related social services as the services provide by the facility's staff to assist residents in attaining, maintaining, or improving their ability to manage every day physical, mental and psychosocial needs. The services outlined in the policy include

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F 745	Continued From page 57 assisting residents with financial and legal matters, The policy also indicated a role of social services was to identify and seek ways to support resident's individual needs through assessment and the care planning process. The procedure identified the social service personnel assists residents in utilizing financial, legal, mental heath and other community resources and agencies for consultation and/or counseling if their needs can not be met by internal Social Work personal.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		1/21/19

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F 755	Continued From page 58 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ophthalmic (eye) medication was discarded timely after being opened and not administered to 1 of 1 residents (R41) observed to receive eye drops during the survey. Findings include: On 11/28/18, at 7:20 a.m. medication administration for R41 was observed. Trained medication aide (TMA)-A removed a box of Cosopt (eye medication used to treat glaucoma) eye drops from the medication cart and brought them into R41's room to administer. There were no visible markings on the box to demonstrate when the eye drops had been opened. TMA-A removed a opened bottle of the eye drops from the box which had a white-colored label. TMA-A administered the eye drops to R41 and then handed the bottle to the surveyor to review. The label had a hand-written "10-15 [Oct. 15th]" on it (43 days prior). When interviewed immediately following, TMA-A reviewed the medicated eye drop bottle and stated it had been opened on 10/15/18, as per the writing on the label. TMA-A explained the bottle should have been discarded after "28 days" and not used adding, "I need to order more."	F 755	R41's eye drops were discarded immediately and reordered. All TMA's and nurses will review Eye Drop Administration Policy. A full house audit was completed to ensure all eye drops have an opened date within a 28 day range. All TMA's and nurses will be review the Eye Drop Administration Policy. Pharmacy has been contacted to access labels to include "opened" and "discard" dates to be placed on the eye drop bottles if available. Random audits of 10% of resident eye drops will be completed weekly x4, biweekly x2 then monthly ongoing to ensure compliance with CMS guidelines related to discard dates. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis.	

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F 755	Continued From page 59 An untitled feature for Cosopt prescribing information dated 07/2016, identified to not use the medication past the expiration date on the bottle; however, lacked any direction or guidelines on how long the medication could be used after being opened and exposed to air and patient contact. On 11/28/18, at 12:57 p.m. the director of nursing (DON) was interviewed and stated eye drops should be discarded 28 days after being opened so they don't lose their effectiveness. The DON added this was a "recommendation" from the pharmacy. When interviewed on 11/29/18, at 1:08 p.m. the consulting pharmacist (CP) stated she had advised her facilities' to discard opened eye drops "28 or 30 days from opening" as it was a recent CMS (Centers for Medicare and Medicaid) guideline. Further, CP stated she had not been involved in revising the current facility' policy for eye drop storage since the CMS guidance was "so recent." A facility provided Medication Administration - Eye Drops and Ointment policy dated 2014-2015, identified a procedure to instill and administer eye drops; however, the policy lacked any direction or guidance on how to store, including duration of time, opened eye medications.	F 755	1-21-19	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		1/21/19

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but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

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F 758	Continued From page 61 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement non pharmalogical interventions and provide clinical justification before using an antipsychotic medication for 1 of 2 residents (R41) reviewed for antipsychotic medication. Findings include: R41's quarterly Minimum Data Set (MDS) dated 10/29/18 identified R41 had severe cognitive impairment. Diagnoses included dementia, depression and anxiety with verbal behavioral symptoms displayed towards others. R41's progress notes identified the following: -11/17/18, 9:54 p.m. R41 had started "howling" in the dining room and was taken back to her room with her meal tray. R41 had continued to "howl and yell" until transferred to her recliner -11/19/18, at 9:58 a.m. R41 had been yelling out and was "rude" to the staff. At 11:01 p.m. R41 had very little "howling", turning on music had been helpful. -11/20/18, at 9:57 a.m. R41 had been "rude" with cares and had refused assistance with toileting. -11/21/18, at 3:13 a.m. R41 had been "howling" and was unable to be redirected. The progress note did not identify what attempts had been	F 758	R41's antipsychotic was discontinued and the care plan was updated with specific interventions. R41 is undergoing medical evaluation/testing and pain medications have been adjusted to ensure comfort. A full house audit will be completed for all residents on antipsychotic medications to ensure proper justification/monitoring and interventions are in place. All licensed staff will review Psychotropic Medication Use Policy. Random audits of up to 100% of the residents on an antipsychotic medication will be completed weekly x4, biweekly x2 then monthly ongoing to ensure residents on antipsychotic medications have the proper justification/interventions and Care plan in place. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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F 758	Continued From page 62	F 758		

made to redirect R41.

-11/21/18, 3:45 p.m. R41 had been "having increased behaviors, being short and rude with staff, swearing at them, and doing some prominent howling" Doctor ordered Seroquel.

R41's physician orders identified the following:
-11/20/18, directed staff to monitor R41's "howling".
-11/21/18, an order was received for Seroquel (antipsychotic) 12.5 mg oral daily with a diagnosis of anxiety disorder.
-11/23/18, add Tylenol (mild pain reliever) 650 mg twice daily for pain.
-11/26/18, Increase Seroquel to 12.5 mg in the morning and 25 mg in the afternoon.

R41's medical record lacked a comprehensive assessment for antipsychotic use to rule out pain, infection or other underlying causative factors for the increase in R41's howling.

R41's care plan revised 11/29/18 indicated R41 had started Seroquel 12.5 milligrams (mg) on 11/21/18 due to R41 "howling", being more angry with staff and not being re-directable. However, the care plan did not identify target behaviors of howling, what non pharmalogical interventions were used to reduce the howling, prior to implementing an antipsychotic medication.

When interviewed on 11/28/18, at 8:39 a.m. NA-F stated R41 was usually pleasant and straightforward about what she wants to have done for her. NA-F was not aware R41 had any behavioral monitoring.

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	245360	A. BUILDING _____ B. WING _____	C 11/29/2018

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F 758	Continued From page 63 During observation on 11/28/18, at 8:41 a.m. R41 sitting in dining room, mood pleasant, talkative with surveyor. When interviewed on 11/29/18, at 2:04 p.m. LPN-D stated when R41 yelled out (howling) R41 had been having pain in her left leg. Tylenol and ice helped relieve the pain she was having and there was no further howling. When interviewed on 11/29/18, at 2:13 p.m. registered nurse (RN)-A stated R41's doctor was in the facility doing rounds and R41 had been yelling out (howling) so the doctor had started her on Seroquel. RN-A stated R41's diagnosis for the Seroquel was depression with anxiety, further stating "that is not a justified use for an antipsychotic." A Behavioral Assessment, Intervention and Monitoring policy revised 3/15, indicated "The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes. When medications are prescribed for behavioral symptoms, documentation will include rational for use and potential underlying causes of the behavior.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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.	F 761		1/21/19

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F 761	Continued From page 64 §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 key(s) to narcotic and controlled substances were secured by licensed and authorized personnel at all times to prevent potential theft and/or diversion. This affected 2 of 3 medication carts housing these medications which had potential to affect 14 of 14 residents identified to have narcotic and/or controlled medications stored inside these carts. Findings include: A facility provided Controlled Substances listing identified a total of 14 residents utilized narcotic and/or controlled substances on the "Maple" and "Pine" medication cart(s). On 11/26/18, at 2:40 p.m. the "Maple" medication cart was reviewed with registered nurse (RN)-B. RN-B explained the cart was locked with a	F 761	Nursing staff were immediately informed of the concern and the issue was corrected. All licensed staff will review the Medication Storage Policy. Key sets allowing access to medication storage areas must be kept with the charge nurse, or in a restricted area at all times. All residents had the potential to be affected. All licensed staff will review the Medication Storage Policy. Random audits of TMA and nurse knowledge will be completed; as well as observation audits to ensure the keys for medication storage areas are secured at all times. These will be completed weekly x4, biweekly x2, then monthly ongoing as determined by the QA committee. In time training will occur immediately upon	

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F 761	Continued From page 65 physical key, and the attached narcotic box was also locked with a different, physical key. The floor nurse had a set of these keys; however, a "master set" also had these keys on it which was housed in the nursing station. RN-B then pointed to a purple colored lanyard which was hung up on the cabinet in the nursing station which was located immediately adjacent to the main commons area with an opened door leading inside the area which housed the keys. The cart was inspected which identified six residents had narcotic medications inside the locked narcotic box. These were counted and found to be correct. On 11/26/18, at 5:02 p.m. the nursing station was observed with the doorway open with nobody seated inside, and the master key lanyard was hanging up on the side of the cabinet for anyone to utilize. On 11/27/18, at 9:49 a.m. the "Memory Care" medication cart was reviewed with RN-C. RN-C explained the cart was locked with a physical key, and the attached narcotic box was also locked with a different, physical key. The floor nurse had a set of these keys along with the master set hung in the nursing station which had an "extra set [of keys] for each cart on there." RN-C added there were currently no residents on the locked memory care unit with narcotic medication(s). On 11/28/18, at 7:05 a.m. housekeeper (HK)-A was using a floor cleaner outside the nursing station. The station' door was open and the master keys were again hanging up on the cabinet. HK-A stated they clean the room and added she was "going in there next."	F 761	identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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F 761	Continued From page 66	F 761		

On 11/28/18, at 8:01 a.m. nursing assistant (NA)-A stated the nursing station was used by the nurses to do their charting and other work; however, NA staff are in there often to get walkie talkies, drop things off and check their mailboxes. NA-A explained people and staff come and go "as they please" in the room as it has never been locked. Further, on 11/28/18, at 9:18 a.m. the nursing station was again observed with the doorway wide open and the master keys visibly hung on the cabinet.

When interviewed on 11/28/18, at 12:57 p.m. the director of nursing (DON) stated the keys were supposed to be carried by the charge nurse and the nursing station' doorway should be locked if nobody was inside. DON added the keys should be stored "so they're not accessible" for other people to obtain and potentially access the medication cart or narcotic storage facilities.

On 11/29/18, at 1:08 p.m. the consulting pharmacist (CP) was interviewed and explained she was "not aware" of the second set of keys being housed inside the nursing station which were accessible to non-licensed personnel. CP stated the keys should be kept on the charge nurse or in a "more restricted area" in accordance with the board of pharmacy requirements.

A facility provided Controlled Substance Storage policy dated 8/2018, identified controlled substances were subject to special handling and storage procedures. The policy directed only authorized licensed nursing and pharmacy personnel should have access to controlled substance and listed a procedure which included, "back-up keys to all medication storage areas, including those for controlled substances, are

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F 761	Continued From page 67 kept by the director of nursing or designee."	F 761		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to ensure the building was kept in good repair. The had the potential to affect all residents and visitors meeting and/or eating in the main dining room, and 3 individual residents residing in rooms 107, 112, and room 126. Findings include: During observations of the facility, the following environmental concerns were noted: On 11/26/18 at 5:18 p.m. the main dining room ceiling was observed to have multiple ceiling tiles with large brown water stains. In the back of the dining room, where church is usually held, there were tiles with large stains approximately 12 inches (in) x 16 in in size, with the tiles hanging down. In the middle of the main dining room, there were three tiles with large dried water stains, approximately 12 in x 12 in. The ceiling vents, that vented heat and air conditioning to the main dining room were covered with fuzzy dust, which coated and hung down approximately 1-2 in on 1 of the vents. In the secured unit, near the door, there were four tiles with dark brown water stains which covered approximately 18 in x 24 in	F 921	The said concerns were corrected during survey. A full house audit was completed and issues were resolved. A daily checklist for housekeeping to sign off on is in use. Issues are resolved or reported to supervisor as they arise to ensure proper follow up. Environmental Services Staff will review Environmental Policy. Random audits of 10% of the resident rooms/living areas will be completed weekly x4, biweekly x2 then monthly ongoing to ensure there are no stains in the ceiling tiles, vents are clean, paint/walls are intact and there are no cobwebs. Issues will be resolved as they are discovered or reported to housekeeping/maintenance supervisor to ensure proper follow up. In time training will occur immediately upon identification of protocol compliance lapse. Analysis of the observations/audits and facility compliance will be presented to our Quality Assurance team and approved by our administrator. The QA team will	1/21/19

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F 921	Continued From page 68 area. During a facility walk through on 11/28/18 12:25 p.m., with the facility administrator (ADM), environmental services director (ESD) and the environmental assistant (EA) reviewed the damages tiles and dust in the vents. ESD and ADM stated the stains were from a leaky room, which were identified on the last recertification survey which exited on 10/26/17. At the time of the last recertification survey, the plan was to repair the roof in the Summer of 2018, with the ceiling tiles would be replaced at that time. The ESD stated he had sprayed the tiles at that time, so they would not be noticeable. The ADM and ESD both stated the roof had been completed about a month ago, and the ceiling tiles replacement was forgotten. Regarding the ceiling vents, the ESD stated the house keepers should be cleaning the vents with the dusters with the extended handles. On 11/27/18 at 3:27 p.m., the following sheet rock issues were noted within the following resident rooms / halls: A. Room (rm) 126 has a gouge approximately 1" x 2" area with sheet rock paper missing, exposing sheet rock gypsum. B. Rm 105 had four gouges with the larger gouge approximately 1" wide x 14 in in length at the head of the bed. There was an air pump for the pressure relieving mattress on the back of the head board causing the gouge in the wall each time the bed was raised or lowered. The air pump scraped against the wall causing the gouges, exposing the dry wall.	F 921	implement needed changes and determine the need for ongoing monitoring/auditing after analysis. 1-21-19	

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F 921	Continued From page 69	F 921		

C. Rm 107 had approximately 5 gouges on the room wall where the bed had been placed against. The gouges were rainbow in shaped, and broke the dry wall paper exposing the inner gypsum. On further inspection, the rainbow pattern came from the 1/2 side rail being raised and lowered with the bed. The high points of the side rail scraped again the wall, causing the damage to the wall.

D. On 11/27/18 at 3:27 p.m., rm 112 had two cob webs approximately 4" and 6" in length, above the window bed holster light fixture.

During a facility walk through on 11/28/18 12:25 p.m., with the ADM, ESD and EA, the ESD stated the house keepers should be cleaning the vents with the dusters with the extended handles. At 1:15 p.m., the ESD stated the facility has a computerized process that all staff have access to, for the reporting of environmental issues needing to repaired by maintenance. He and EA weekly pick 2-3 rooms and do a walk through. They were unaware of any of the dry wall issues. ESD stated the cob webs in rm 112, should never of happened since each housekeeping cart had long handled duster, which can extend and reach high spots in the rooms and halls. After review of the housekeeping scheduled duties, ESD identified the ceiling vents in the main dining room were not on the housekeepers list and would be added.

A facility policy for routine maintenance were requested, but not received. ESD stated that they do not have a policy but rather a document entitled" Housekeeping Daily Checklist (undated), that listed the housekeeping job duties and how to report concerns to the maintenance

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F 921	Continued From page 70 department. ESA stated that there are posted in all the housekeeping closets.	F 921		

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2018**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Living Community of New London was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Benedictine Living Community of New London is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II(000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II(000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II(000) construction. The building is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 52 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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

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