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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WOFB
Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245183**

2. STATE VENDOR OR MEDICAID NO. (L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

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) **01/01/2014**

6. DATE OF SURVEY **02/01/2019** (L34)

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	

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

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

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

12.Total Facility Beds **320** (L18)

13.Total Certified Beds **320** (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
	320			
(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:
Susanne Reuss, Unit Supervisor 04/17/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 04/17/2019 (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 **05/01/1972** (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. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/27/2018** (L33)

DETERMINATION APPROVAL

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

Electronically delivered

CMS Certification Number (CCN): 245183

February 8, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

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 February 1, 2019 the above facility is certified for:

320 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 320 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On January 31, 2019,

I, Diane Willette, Administrator, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated January 31, 2019 and issued to:

North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

The Penalty Assessments attached hereto have been corrected as of January 31, 2019.

Signed: Diane Willette, Administrator, Date 1-31-19
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On January 31, 2019,

I, Amy Charais, HFETI, of the Division of
(Name)(Please Print) (Title)(Please Print)
Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated January 31, 2019 and issued to:

North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

The Notice of Penalty Assessment was handed to Diane Willette,
(Name)(Please Print)
Administrator, Date 1/31/19
(Title)(Please Print)

Signed: [signature], HFETI, Date 1/31/19
(Name)(Please Print) (Title)(Please Print)

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

Electronically delivered
February 8, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number S5183030, H5183156, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, H5183167, H5183172, H5183174, and H5183175

Dear Administrator:

On August 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 27, 2018. (42 CFR 488.422)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018. (42 CFR 488.417 (a))

On October 5, 2018, November 29, 2018, and January 19, 2019, we informed you that the following enforcement remedy was being recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office:

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

On January 25, 2019, the CMS Region V Office notified you of the following actions:

- Mandatory termination effective February 10, 2019.

On February 1, 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 abbreviated standard surveys, completed on August 10, 2018, September 13, 2018, and October 18, 2018, a standard survey, completed on November 8, 2018, as well as a PCR, completed on January 4, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 1, 2019. We have determined, based on our visit, that your facility has corrected the deficiencies issued as of February 1, 2019.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 1, 2019.

However, as we notified you in our letter of August 22, 2018, in accordance with Federal law, as

specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018 be discontinued as of February 1, 2019. (42 CFR 488.417 (a))

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

- Mandatory termination effective February 10, 2019 be discontinued as of February 1, 2019.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: Reinspection Results - Project Numbers S5183030, H5183156, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, H5183167, H5183172, H5183174, and H5183175

Dear Administrator:

On February 1, 2019, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the surveys completed on August 10, 2018, September 13, 2018, October 18, 2018, November 8, 2018, and January 4, 2019, with orders received by you. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

Electronically Delivered

March 5, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number S5183030, H5183168, H5183170, H5183171, H5183172, H5183173, H5183156

Dear Administrator:

On January 31, 2019, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on January 31, 2019, imposed a daily fine in the amount of $1500.00.

On January 22, 2019, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on February 1, 2019 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $1500. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $353.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $1853.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

An equal opportunity employer.

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WOFB
Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245183**

2. STATE VENDOR OR MEDICAID NO. (L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

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) **01/01/2014**

6. DATE OF SURVEY **01/04/2019** (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 **320** (L18)

13. Total Certified Beds **320** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(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: Susanne Reuss, Unit Supervisor — Date: 01/19/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL: Douglas Larson, Enforcement Specialist — Date: 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 **05/01/1972** (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. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/27/2018** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number S5183030, H5183156, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, H5183167, H5183172, H5183173, H5183174, H5183175, and H5183176

Dear Administrator:

On August 22, 2018, we informed you that the following enforcement remedies were being imposed:

• State Monitoring effective August 27, 2018. (42 CFR 488.422)

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018. (42 CFR 488.417 (a))

Also, we notified you in our letter of August 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

On October 5, 2018, and on November 29, 2018, we informed you that the following enforcement remedy was recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office:

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

On January 4, 2019, the Minnesota Department of Health, along with the Minnesota Department of Health, Office of Health Facility Complaints, completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to abbreviated standard surveys, completed on August 10, 2018, September 13, 2018, and October 18, 2018, as well as a standard survey, completed on November 8, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 18, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued. In addition, at the time of the January 4, 2019 PCR the Minnesota Department of Health completed an investigation of complaint numbers H5183174, H5183175, and H5183176. The deficiencies not corrected are as follows:

F0550 -- S/S: D -- 483.10(a)(1)(2)(b)(1)(2) -- Resident Rights/exercise Of Rights

F0584 -- S/S: E -- 483.10(i)(1)-(7) -- Safe/clean/comfortable/homelike Environment
F0677 -- S/S: D -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents
F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices
F0725 -- S/S: E -- 483.35(a)(1)(2) -- Sufficient Nursing Staff
F0761 -- S/S: D -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals

In addition, at the time of this revisit, we identified the following deficiency:

F0803 -- S/S: D -- 483.60(c)(1)-(7) -- Menus Meet Resident Nds/prep In Adv/followed

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the previously imposed remedies of state monitoring, discretionary denial of payment (42 CFR 488.417 (a)), and civil money penalty (42 CFR 488.430 through 488.444) will remain in effect.

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

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

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

As we notified you in our letter of August 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the standard survey completed November 8, 2018, and revisit completed January 4, 2018), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the abbreviated standard surveys completed August 10, 2018, September 13, 2018, and October 18, 2018, and revisit completed January 4, 2018), i.e., the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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 February 10, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING ______ B. WING ______	R-C 01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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 11/4/18 through 11/8/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An on-site revisit was completed 1/2/19 through 1/4/19. The facility was found NOT to have corrected one or more deficiencies issued as a result of the survey exited on 11/8/18. In addition complaints substantiated as a result of the 11/8/18 were reviewed as well as additional complaint investigations at the time of the revisit: H5183172: At the time of the 11/8/18 survey, an investigation of this complaint was completed and substantiated at F584. At the time of the revisit, complaint H5183172 was not corrected, and reissued at F584. H5183173: At the time of the 11/8/18 survey, an investigation of this complaint was completed and substantiated at F580, F677, F686, F690 and F725. At the time of the revisit, complaint H5183173 was not corrected, and reissued at F686 and F725. H5183174: was investigated at the time of the revisit survey. The complaint was substantiated at F550, F689 and F803. H5183175: was investigated at the time of the revisit survey. The complaint was substantiated at F677.	{F 000}		

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

Electronically Signed — 01/22/2019

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

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{F 000}	Continued From page 1 H5183176: was investigated at the time of the revisit survey. The complaint was found to be unsubstantiated. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 550} SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	{F 550}		1/24/19

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{F 550}	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignified treatment for 1 of 1 residents (R701) reviewed for reported concerns related to staff treatment. Findings include: R701's Care Area Assessment (CAA) assessment dated 11/27/18, included diagnoses cerebrovascular accident and hemiplegia/hemiparesis. R701's care plan date revised on 1/3/19, identified R701 had physical mobility limitations, cognitive communication deficit and anxiety and directed staff to "give clear explanation of all care activities prior to an as they occur during each contact" and extensive assist of 2 staff members for transfers and toileting needs.	{F 550}	R701 was interviewed and a grievance was completed on 1/2/19 by the Assistant Administrator. In response to the grievance, the community has added a task to her Kardex and to her MAR to remind the staff to knock on the door, introduce themselves and communicate what tasks they will be completing. An erasable white board has been placed in the resident□s room to note the names of the Nurses and Nursing Assistants assigned for the shift. In addition, the resident is being visited daily (M-F) and will continue daily until January 31, 2019 by a member of the administration staff or their designee to follow up on the new process. A weekly call with the resident□s daughter has been initiated by the Social	

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{F 550}	Continued From page 3 During an interview on 1/2/19, at 10:27 a.m. R701 was observed seated in her wheelchair. R701 indicated her daughter had recently posted a sign in her room which requested staff to introduce themselves, let her know why they are entering the room, and inform her prior to providing cares; this was due to staff entering her room refusing to identify themselves and not explaining interactions. R701 also stated staff have been rude to her many times and made remarks that were not respectful. During an observation on 1/2/19, at 11:37 a.m. registered nurse (RN)-B entered R701's room along with RN-C; RN-B knocked on R701's door and as she entered stated they were going to help her to use the bathroom and entered the room without identifying themselves. RN-B and RN-C assisted R701 to the bathroom and exited the room as nursing assistant (NA)-E and NA-B entered the room and neither one introduced themselves. As NA-B moved the lift away from the toilet R701 yelled "why did you do that" R701 further stated "I already wiped, please talk to a person before you wipe them with that cold wet thing." NA-E stated, "Sorry." During an interview on 1/2/19, at 1:47 p.m. NA-E verified that she did not notify R701 prior to providing pericare. During an interview on 1/2/19, at 1:54 p.m. R701 stated when she used the bathroom it was "pretty uncomfortable and embarrassing." R701 indicated the staff had used a cold wet wipe to cleanse her bottom without telling her what she was going to do and further stated, "she was wiping me in the middle of my back and I was so	{F 550}	Worker to follow-up on any concerns voiced by her mother. Investigation completed on the specific issue noted in the 2567 resulted in staff education starting on 1/07/19, on knocking on the door, entering and identifying yourself, and explaining why you are there. Interviewable residents will be met with by the administrative staff/ or designee to identify possible concerns relating to resident rights and dignity. Upon the completion of the interviews, the concerns will be addressed and outcomes of results will be reviewed to identify any additional process improvement. Current staff will be re-educated and new staff will be educated on our policies and procedures pertaining to resident rights, which includes dignity by the Director of Education and/or administrative staff. Education will be completed by 1/24/19. Each unit will have weekly meetings to address concerns related to resident rights and dignity, starting 1/23/19. These meetings will be led by the Administrator of the Unit or Social Services staff. The ombudsman was notified on 1/22/19 of the occurrence of the meetings. Concerns identified through the weekly meetings will be reviewed weekly x 4 weeks, then monthly x 2 or until a lesser frequency is identified by Administration with ongoing education to staff related to findings.	

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{F 550}	Continued From page 4 cold already." R701 verbalized had she known what the staff was going to do she would have declined the wipe as she had already completed the task. Furthermore, R701 stated, "I just want them to tell me their name it's basic manners." During an interview on 1/3/19, at 1:51 p.m. the director of nursing stated it was her expectation for staff to identify themselves as they begin interacting with a resident and to explain all interactions. The facility policy Respect and Dignity, Right to Personal Property revised date November 2017, indicated, "Residents have the right to be treated with respect and dignity ..."	{F 550}	Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x 4, monthly x 2.	
{F 584} SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	{F 584}		1/24/19

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{F 584}	Continued From page 5 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R95, R703, R704) wheelchairs were kept clean. In addition, failed to ensure rooms were kept clean for 1 of 1 resident (R16) with respiratory concerns. Findings include: R95's diagnoses included cerebral palsy, muscle weakness, profound intellectual disability and scoliosis obtained from the quarterly Minimum Data Set (MDS) dated 12/1/18. In addition, the MDS indicated R95 had severely impaired cognition, required total dependence of two staff with transfers, one assist with locomotion in the unit, used a wheelchair (w/c) and had functional	{F 584}	R95, R703, and R704 wheelchairs were cleaned immediately R16□s radiator and CPAP were cleaned immediately. An audit will be completed by administrative staff/or designee of resident wheelchairs to establish that wheelchairs are free of debris. Administrative staff will complete an audit of resident rooms and common spaces to identify environmental concerns. Contracted housekeeping staff re-educated on finding and expectations of community cleanliness. Nursing staff re-educated on wheelchair cleaning	

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{F 584}	Continued From page 6 limitation to both lower extremities. R95's care plan dated 8/20/18, indicated R95 had limited physical mobility related to cerebral palsy and profound mental disability. The care plan indicated R95 used a wheelchair for locomotion and staff propelled her to specific destinations. In addition, the care plan indicated for transfers R95 required assist of two to transfer from bed to w/c. On 1/2/19, at 1:42 p.m. R95 was observed lying in bed and her specialized wheelchair (w/c) was observed parked at the base of the bed. The w/c was observed to be heavily soiled with whitish and brownish multiple food spills on the w/c frame. On 1/3/19, at 8:43 a.m. R95 was observed to be all dressed for the day and was seated on the w/c by the nursing station as multiple staff went by, however, none acknowledged the w/c needed to be cleaned. On 1/3/19, at 9:00 a.m. to 9:22 a.m. registered nurse (RN)-A assisted R95 with breakfast. During the observation R95's w/c was observed soiled. At 9:23 a.m. RN-A was observed to wheel R95 to her room. On 1/3/19, at 9:38 a.m. the director of maintenance stated wheelchair cleaning was done by the security staff at night and at times the maintenance staff cleaned them in the evening. When asked how his department was notified of soiled w/c's when it was not the scheduled time to be cleaned, the director of maintenance stated nursing staff would notify his department and when he got any notification he would pull and cleaned the w/c immediately.	{F 584}	process by nursing administration. Maintenance staff re-educated on wheelchair cleaning process by administrative staff. Administrative staff/or designee will complete five wheelchair audits will be completed per unit to establish that wheelchairs are free of debris daily x 7 days, twice weekly x 2 weeks, weekly x 4 and monthly x 3. Administrator/ or designee will complete weekly rounds x4 weeks with contracted housekeeping staff to establish cleanliness of community. Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x4, monthly x2, and quarterly.	

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{F 584}	Continued From page 7 -At 9:42 a.m. the director of maintenance reviewed the monthly wheelchair log and verified R95's w/c was last cleaned the first week in December 2018. -At 9:46 a.m. the director of maintenance verified the w/c was soiled, "it is dirty for sure. I talked to the nurse couple of times about cleaning it but don't have documentation for it because we have been having problems having access to it to be cleaned. I did not talk to [security staff] why it was not done at night as he comes at 11:00 p.m. I need to coordinate with nursing when is a good time to have it cleaned maybe when she is getting a shower. The wheelchair needs to be taken down to the machine to be cleaned because it is dirty." The undated facility Wheelchair Cleaning policy directed staff wheelchairs were to be washed monthly following the wheelchair washing schedule and as needed. In addition, the policy directed nursing staff to wipe down wheelchairs for spills and debris and for excessively soiled wheelchairs the staff was to put in "TELs" for maintenance to clean through the wheelchair machine. R703 was observed on 1/2/19, at 1:19 p.m. seated in a tilt in space wheelchair. The left foot rest of the chair was hanging off to the side of the chair. Staff adjusted the foot rest, however, the foot rest did not stay in place causing R703's foot to dangle in the air. The left foot pedal did not match the one on the right side of the chair. R703's wheelchair was covered with food debris on the cushion, arm rests and wheels. A Progress Note dated 11/21/18, indicated R703	{F 584}		

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{F 584}	Continued From page 8 transferred from another unit and indicated: foot rest on residents wheelchair was broken. R704 was observed on 1/3/19, at 11:47 a.m. and R704's wheel chair was noted to be covered in food debris and had a substance all over the wheels of the chair. During interview on 1/3/19, at 11:40 a.m. licensed practical nurse (LPN)-C stated the resident wheelchairs were supposed to be cleaned on the night shift. She stated R703's chair should have been cleaned on 12/30/18. LPN-C further stated she had completed a work order for the broken foot rest on R703's chair. At 11:47 a.m. RN-E stated a wheelchair cleaning schedule was posted on the wall at the nurses station. RN-E stated there had been a breakdown in communication and felt it was on the night shift. R16 was admitted to the facility on 7/26/18, and had diagnoses including acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. R16's brief interview for mental status (BIMS) score was 15 (13-15 indicates intact cognition). R16's room was observed on 1/3/19, at 9:20. The heater/radiator fan, located underneath the window sill, was full of dirt and debris. The fan blew out cold air. The housekeeper went into R16's room at 9:25 a.m. after the housekeeper left the room (approximately 9:40 a.m.), the fan was still dirty and full of debris.	{F 584}		

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{F 584}	Continued From page 9	{F 584}		

Continued From page 9

R16 was interviewed on 1/3/19, at 1:29 p.m. and said she washed 2 of the 7 vent panels of the fan herself. During the time of the interview, the fan blew out cold air. Dust debris was noted on the back of the closet door that was closest to the fan. A continuous positive airway pressure (C-PAP) machine (a machine that is a constant flow of airway pressure to the throat and ensures the airway stays open during sleep) was approximately 8 feet away from the fan, also had dust and debris on it. R16 indicated she had breathing problems and used oxygen and the C-PAP machine at night.

Maintenance staff-C was interviewed on 1/3/19, at 1:43 p.m. and indicated the fan needed to be cleaned and was last cleaned in the summer. Maintenance staff-C said the fans were cleaned twice a year.

An environmental tour was done with the maintenance director on 1/4/19, at 9:30 a.m.. The maintenance director said the fans are on a schedule to be cleaned once a month and housekeeping staff also cleaned the fans.

The housekeeping director was interviewed on 1/4/19, at 11:43 a.m. and said housekeeping staff cleaned the top of the heat registers/fans. Housekeeping staff did general cleaning to a room each day and did a deep cleaning of one room each day. There were 18 rooms on R16's unit and the housekeeping director indicated that every 18 days each room would receive a deep clean. Number 6 of the daily deep clean check off list included: clean and wipe done heater/radiator units/tear apart to clean and vacuum filter and clean floor underneath.

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{F 677}	Continued From page 10	{F 677}		
{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 ensure adequate grooming assistance for 1 of 3 residents (R62) reviewed for activities of daily living. Findings include: R62's annual Minimum Data Set (MDS) dated 11/16/18, indicated he was severely cognitively impaired and required assistance from staff for dressing and personal hygiene. During observation on 1/3/19, at approximately 12:15 p.m. R62 was seated in the dining room awaiting his noon meal. R62's face was unshaved and his pants were covered in what appeared to be food debris. During interview on 1/3/19, at 12:30 p.m. nursing assistant (NA)-E stated she had assisted R62 with cares that morning. NA-E stated she did not think R62's pants were dirty when she put them on him. NA-E further stated she attempted to shave R62 with an electric razor but he had refused. On 1/3/18, at 12:40 p.m. registered nurse (RN)-F stated R62 did not have an electric razor. She stated he used to but it had been missing for a while. RN-F stated staff should be using a	{F 677}	R62 was shaved and his room and clothing were cleaned. His personal razor was located and placed at the nurses station. In addition a specific task was added to his Point of Care regarding the use of a spill free cup at meals, the location of his razor and to ensure his dirty clothes are sent to the laundry. The care plan and kardex was updated to reflect his dressing needs and habits. Each residents kardex is being reviewed for appropriate transfer, shaving, continence needs, bathing preferences, mobility, adaptive equipment needs, dining preferences, and repositioning. Updates to the kardexs are occurring as changes are identified. This will be completed by 1/24/19. Current staff will be re-educated, and new staff will be educated on using the kardex by the director of education and/or designee to meet ADL needs. Monitoring of ADL care will be completed through an audit of five residents per unit to monitor compliance with daily ADLs by administrative staff daily x 7 days, twice weekly x 2 weeks, weekly x 4 and monthly x 3.	1/24/19

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{F 677}	Continued From page 11 disposable razor to shave him. At 2:23 p.m. RN-E stated R62 would change into his dirty clothes after the staff assisted him in the morning. She stated his dirty clothes were kept in his closet even though she was aware of this behavior.	{F 677}	The Kardex will be developed and reviewed thru the Interdisciplinary Team process upon admission, with significant change, quarterly and annually. Results of the ADL audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x4, monthly x2, and quarterly or until a lesser frequency is identified.	
{F 686} SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to promote healing of pressure ulcers and prevent pressure ulcers for 2 of 3 residents (R28, R143) reviewed for pressure ulcers. This resulted in actual harm for R28 who's pressure ulcer worsened to a stage IV.	{F 686}	R28 □ Patient at Risk (PAR) meeting held on 1/2/19, the coccyx wound was evaluated and measurements noted. On 1/4/19, the right shoulder wound was evaluated, the family was notified. The care changes included a Broda chair to relieve pressure on the shoulder and encouragement to the resident to return to	1/24/19

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{F 686}

Continued From page 12

Findings include:

R28's quarterly minimum data set (MDS) dated 11/9/18, indicated she was moderately cognitively impaired and required extensive assistance with bed mobility, transfers and toileting. The MDS further indicated R28 did not have a pressure ulcer. R28's care plan dated 12/11/18, identified a potential/actual impairment to skin integrity related to immobility and fragile skin. The care plan directed staff to lay R28 down after meals, document location, size and treatment of skin injuries and reminders to turn and reposition.

A facility Progress Note dated 9/5/18, indicated: pressure ulcer to coccyx noted on 9/3/18, "1/2x 0. .1 cm [centimeters]." R28 with new pressure wound to coccyx area to same spot where recent pressure wound healed. Area is compromised and at risk for recurrent injury given the current underweight status and poor appetite. Keep resident off wheel chair in between meals

During a continuous observation on 1/4/19, the following was observed: At 7:07 a.m. R28 was up seated in her wheel chair outside the nurses station. At 7:40 a.m. R28 was escorted to the dining room by staff where she remained until 9:52 a.m. At that time, staff escorted R28 to her room and placed her in front of the television without repositioning her.

On 1/4/19, at approximately 10:00 a.m. licensed practical nurse (LPN)-B stated he was aware R28 had a wound on the right side of her buttock but was not sure how long it had been there. LPN-B stated he did not usually work on that unit.

At 10:07 a.m. nursing assistant (NA)-A stated

{F 686}

bed after lunch. On 1/4/19, the resident□s NP noted that her skin breakdown is expected part of her disease progression. On 1/7/19 and 1/8/19 the wounds were re-assessed. The shoulder wound was superficial and healing. The coccyx wound was reassessed on 1/9/19 and a PAR meeting was held. The shoulder wound has healed. On 1/11/19 a PAR meeting was held, the resident is noted to be declining in status. 1/15/19 new orders for residents wound obtained through Hospice provider. On 1/21/19 the care plan was updated to state, encourage the resident to lay down after meals instead of just after lunch. 1/22/19 an order to apply a protective dressing to her shoulder was obtained. Turning and repositioning re-education based upon our policy was begun with the staff on 1/7/18 and is ongoing.

R143 □ Resident is currently not in the community as of 1/21/19. On 1/8/19 the resident□s care plan was updated to reflect her scratching of her buttocks and to review her current desire to not reposition. On 1/23/19, a task was added to the Point of Care system to reflect her refusal to offload or reposition in anticipation of her return to the community. At that time a new assessment will be completed.

Residents with Braden Scores which reflect moderate to high risk for pressure injuries and have existing pressure injuries were identified through their assessments (Braden and Pressure Ulcer

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{F 686}	Continued From page 13 R28 was frail and had been having a lot of problems with her bottom. NA-A stated R28 was supposed to be repositioned every two hours and stated it had not been done since R28 had gotten out of bed that morning. NA-A stated she had not had time to reposition R28. At 10:30 a.m. LPN-B and NA-A assisted R28 to lay down in her bed. R28 was noted to have a reddened area on her ischium approximately one inch round. LPN-B removed a dressing from R28's coccyx. LPN-B described R28's wound as approximately 5 cm x 4 cm with tunneling. The wound bed contained slough (dead tissue) and was described by LPN-B as a stage IV (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. pressure ulcer). LPN-B stated R28 also had a pressure ulcer on her shoulder that had been present for about a month. R28's Nursing Weekly Skin Evaluations and Skin Condition Reports revealed the following: 12/12/18, Right gluteal fold maceration first observed on 9/5/18. 12/18/18, Skin condition dry, redness. No area identified. 12/25/18, Skin intact, no open areas. 12/26/18, right gluteal fold macerations. No measurements included. 1/1/19, Coccyx pressure ulcer unstageable measuring 1.5 cm x 2.2 cm. Wound bed eschar, surrounding tissue macerated. The medical record lacked further documentation of the right gluteal fold and lacked documentation related to the shoulder.	{F 686}	Report). This identified sample of residents care plans and kardex tasks were reviewed for accuracy in turning and repositioning schedules. The residents in this sample, whom are also in the dining room for meals, will be identified and monitored by the nursing staff for off-loading and pressure re-distribution according to their care plan and specific tasks noted in Point of Care. Re-education will be provided to licensed nursing staff on wound assessment, documentation, prevention and treatment by a wound certified nurse by 1/24/19. The Certified Nursing Assistants will be re-educated on how to access residents turning and repositioning schedules in Point of Care and on the Kardex. Monitoring will include audits on the current residents with pressure injuries to monitor compliance with repositioning by administrative staff daily x 7 days, twice weekly x 2 weeks, weekly x 4 and monthly x 3. The results of the repositioning audits will be reviewed in daily stand down meeting, daily M-F or until a lesser schedule is identified. Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x 4, monthly x2, and quarterly.	

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{F 686}	Continued From page 14 Following the survey the provider submitted the following Progress Notes: 1/4/19, Progress Note written by LPN-B: Stage II (involve partial thickness skin loss involving epidermis, dermis, or both. The lesion is superficial and presents clinically as an abrasion, blister, or shallow center) pressure ulcer noted to back of left shoulder measuring .5 cm x .5 cm. Hospice nurse updated and said she was aware of the wound and indicated it had been only redness previously. During interview on 1/4/19, at RN-A stated she was not aware R28 had a history of pressure ulcers to her coccyx and stated she was not aware of the pressure ulcer on her shoulder. RN-A stated the standard of practice for repositioning a resident with a pressure ulcer was every two hours and stated she expected the repositioning to be done according to the plan of care. At 11:39 a.m. the director of nursing stated she expected staff to follow the plan of care and stated R28 should have been repositioned every two hours. R143's quarterly MDS dated 12/24/18, indicated she had intact cognition, required extensive assistance from two staff for bed mobility, toileting and transfers and had a stage IV pressure ulcer. R143's care plan dated 10/2/18, identified bladder incontinence related to impaired mobility and a stage IV pressure ulcer to her coccyx. The care plan directed staff to encourage her to turn and reposition "at least" every two hours.	{F 686}		

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{F 686}	Continued From page 15 A care area assessment indicated R143 admitted to the facility with a pressure injury, healing stage IV and an area on her left heel. History of non-compliance with off loading and repositioning. During continuous observation on 1/3/19, the following was observed: At 7:34 a.m. R143 was observed up in her wheel chair in her room. At 8:03 a.m. she was seated at a table in the dining room where she remained until 9:01 a.m. when she propelled herself to an adjoining activity room. At 9:35 a.m. R143 propelled herself to her room and sat in her wheel chair facing the window. At 9:52 a.m. a staff member entered the room to get a room tray and immediately left. At 10:13 a.m. R143 remained seated in her wheel chair. R143 stated the staff only help her in the morning and at night. At 10:25 a.m., two hours and thirty nine minutes from the initial observation, RN-A and NA-F assisted R143 to stand using a mechanical device, after surveyor alerted RN-A of the last time R143 had been repositioned. R143 had a wound on her coccyx and two open areas on the right and left buttock. RN-A stated the the two areas on R143's buttock were new. The left buttock had a superficial open area approximately one inch. The right buttock was a superficial open area approximately two inches in length. A Weekly Skin Condition Report dated 12/18/18, indicated R143 had a stage IV pressure ulcer on her coccyx measuring 2.0 cm x 1.3 cm x 1 cm.. A facility Progress Note date 1/3/19, following observation with surveyor indicated: Writer spoke to nurse practitioner about superficial open areas	{F 686}		

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{F 686}	Continued From page 16 on left and right buttock. Nurses practitioner stated barrier cream should be applied and areas covered daily.	{F 686}		
{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 promote safety with the use of a mechanical standing lift during transfers for 1 of 2 residents (R701) reviewed for accidents. Findings include: R701's Care Area Assessment (CAA) assessment dated 11/27/18, included diagnoses of cerebrovascular accident and hemiplegia/ hemiparesis. In addition, the CAA indicated R701 had confusion, disorientation, forgetfulness and functional limitation in range of motion. R701's care plan date revised on 1/3/19, identified R701 had limited physical mobility related to weakness and hemiplegia affecting the left side and directed 2 staff to assist with transfers utilizing the standing lift. The care plan further indicated, "weight baring [sig] as tolerated, but left sided hemiparesis."	{F 689}	R701 was re-evaluated by therapy for safe transfers on 1/09/19. The task in Point of Care was added on 1/23/19 to reflect the safety concerns of using an EZ stand vs a mechanical lift. This was discussed with the resident. The nursing assistant involved was re-educated on the use of the EZ Stand and Mechanical Lift on 1/9/19. Current residents who depend on mechanical lifts will be identified and then audited to verify safe transfers are completed by administrative nursing staff. Current nursing staff will be re-educated and new nursing staff will be educated on safe transfers using mechanical lifts that follow personalized kardex by director of education or nursing administration. Compliance will be monitored through 5	1/24/19

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{F 689}

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During an observation on 1/2/19, at 11:37 a.m. registered nurse (RN)-B entered R701's room along with RN-C, RN-B stated they were going to help her use the bathroom. RN-B raised the stand lift to an upright position, R701 was standing while bending over at the waist wearing regular socks without gripper on the bottom, her left foot was inverted as she was standing on her outer left side of her foot. While RN-B was pushing the standing lift from R701's room into the bathroom she stated, "Pull down her pants quick she's starting to slip." During this time R701 was observed to have her knees bent, both feet appeared to be sliding toward the front of the standing plate, the stand sling was near her upper shoulders/ neck area and the left side of the sling at her upper arm/ bi-cep area. RN-C was observed to remove R701's pants as she was lowered by the standing lift to the toilet. RN-B verbalized they needed to talk with therapy due to R701's weakness and inability to stand up. RN-B and RN-C exited the room as nursing assistant (NA)-E and NA-B entered the room, and NA-B asked R701 if she was ok. R701 responded, "I am just very sore I need to get back to bed." As R701 was being raised into an upright position she stated "ow, ow, my foot." R701 was observed to be standing on the outer left side of her foot as her foot was inverted.

During an interview on 1/2/19, at 1:06 p.m. RN-C identified R701 had been evaluated a few weeks ago for the use of the standing lift by therapy and further stated at times R701 will slide down in the standing lift and look like she was "not standing," however therapy said for her to use the standing lift.

During an interview on 1/2/19, at 1:47 p.m. NA-E

{F 689}

audits of transfers daily x 7 days, twice weekly x 2 weeks, weekly x 4 and monthly x 3 to verify safe transfer with mechanical lifts per kardex or until a lesser frequency is identified.

Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x4, monthly x2, and quarterly.

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{F 689}	Continued From page 18	{F 689}		

identified she did not know R701 well and was not sure when R701's leg brace was to be worn and if it was needed for transfers.

During an interview on 1/2/19, at 1:54 p.m. R701 stated the observed transfer to the bathroom was "pretty frightening because I was slipping." R701 indicated her left foot was contracted and that she had a leg brace that should be worn to help support it. Furthermore, R701 stated the transfer back from the bathroom was "very painful" to her left foot as it caused a "sharp pain."

During an interview on 1/3/19, at 7:25 a.m. physical therapist (PT)-A identified there was gripper on the stand plate for the standing lift machine, however, to promote proper foot alignment and even weight distribution resident's should wear gripper sock or shoes when being transferred with the standing lift. PT-A stated that he was not notified by the nursing department regarding any difficulties or changes with R701's transfers. PT-A indicated a training had occurred a few weeks ago when R701 had transitioned to the standing lift and during this training all staff were notified that R701 should wear her left leg brace during transfers.

During an interview on 1/3/19, at 8:29 a.m. RN-D stated R701 should be wearing tennis shoes not only socks during standing lift transfers and was not aware of when the leg brace should be worn.

During an interview on 1/3/19, at 1:51 p.m. the director of nursing stated it was her expectation for residents to wear gripper socks or shoes during standing lift transfers.

The facility policy Lifting Machine, Using a

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{F 689}	Continued From page 19 Portable revised October 2010, indicated to document in the resident's medical record "5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 6. Any problems or complaints made by the resident related to the procedure."	{F 689}		
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	{F 725}		1/24/19

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{F 725}

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by:
Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement accommodation of needs, with timely assistance, for personal cares according to the residents' assessed needs and as directed by the care plan. This practice had the potential to affect all residents residing on the 2 W unit.

Findings include:

Refer to F686: The facility failed to ensure 2 of 3 residents (R28, R143) identified at risk for pressure ulcers received timely repositioning. The failure of the facility to implement interventions resulted in actual harm for R28 whose pressure ulcer worsened.

Staff interviews:
On 1/2/19, at 10:06 a.m. nursing assistant (NA)-C stated staffing was still a concern and times staff was being cut with low census and the management did not pay attention to the care level of the residents including those that needed two assist with transfers and 2 with cares, "It's not about the number it's the care level. They can cut but they need to look at the care level."

On 1/2/19, at 10:13 a.m. NA-D stated staffing had not gotten any better and this was a facility wide concern that staff were being cut without looking at the care needs of the residents, "sometimes the teams are split."

On 1/4/19, at 9:58 a.m. when NA-G stated, "We don't have enough people, we only have three aides" and "our brakes are taken out of our checks but we don't get them." When asked why

{F 725}

A contract with a nursing agency has been obtained and contracted nursing assistants have been utilized since 1/18/19.

The acuity of the current residents has been assessed through reports titled Case Mix Report and ADL Index Report. A tally of residents has been obtained for the following tasks, feeding assistance and those requiring mechanical lifts for each unit.

Staffing levels were assigned based upon the above reports which reflect acuity.

A wage review for nursing assistants will be completed by 1/24/19.

At the change of each shift, the Nursing Supervisor verifies all staff scheduled are present.

Monitoring of daily staffing is done by the Staffing Coordinator and reported at daily stand up (M-F). Staffing will be reviewed by administrative staff/or designee throughout the day and agency will be contacted for any unexpected changes. Team Leaders on each shift will validate their assigned team members are present at the beginning of each shift. The staffing office or shift supervisor will be notified of staff whom have not reported for duty. The nursing staff will be re-educated on this procedure.

Meetings held 5 days a week, M-F to

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{F 725}	Continued From page 21 R28 was not repositioned timely according to the care plan. On 1/4/18, at 1:07 p.m. NA-A stated, "We don't have enough staff to reposition our residents on time" when asked why R28 was not repositioned timely according to the care plan. On 1/4/19, at 11:33 a.m. NA-A stated she was not aware R143 wasn't repositioned on time and stated, "We are swamped, we don't have time." Record review: On 1/4/19, at 1:04 p.m. during a review of randomly selected staff schedules and staffing posting with the staffing coordinator, administrator and the human resource director the following was revealed on four of seven days selected: -12/31/18, for the evening shift which started at 2:00 p.m. to 10:00 p.m. one nursing assistant (NA) on 1 SW and one NA on 2 West schedules had instead worked 3:00 p.m. to 9:00 p.m. In addition, one NA on 3 West had left early but it was not identified how early. -12/29/18, for the evening shift 3 W schedule revealed one NA had a no call no show (NCNS) which was never replaced. -12/28/18, for the day shift on 1 SW schedule revealed one NA had come in late for the 6:00 a.m. to 2:00 p.m. and one NA only worked 2:00 p.m. to 7:00 p.m. instead of 2:00 p.m. to 10:00 p.m. -12/23/18, for the day shift in the Transitional Care Unit (TCU) a 6:00 a.m. to 2:30 p.m. nurse was floated to 2 W and the schedule indicated	{F 725}	review open positions and new hires. Ongoing exploration of recruitment efforts evaluated weekly. Results of the findings will be forward to the QAPI committee for continued quality improvement and compliance weekly x4, monthly x2, and quarterly.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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 725}	Continued From page 22	{F 725}		

"Group 8 Nurse will work as Nurse and CNA." In addition, the same TCU unit had one NA NCNS which was never replaced.

During the review, the staffing coordinator verified on days staff had NCNS's no staff was found to replace them. When asked what the staffing pattern for 2 W was the staffing coordinator stated the unit was staffed with 4 nurses and 6 NAs at current average census of 66-68. When asked if the acuity, the level of assistance residents needed such as transfer level, repositioning assistance and other care needs which required more than one staff assistance, the staffing coordinator was not able to respond. When asked how she determined the staffing pattern for the facility the staffing coordinator stated it was determined by the director of nursing and the administration team. The staffing coordinator stated admissions and discharges were communicated throughout the day to determine staffing needs for the facility. When asked what happened when the census was low, the staffing coordinator stated when significantly low the facility flexed down. At 1:24 p.m. when asked if staff had brought complaints of insufficient staffing to her, the staffing coordinator stated, "Occasionally on TCU when census is in flex they say they don't know how to divide the groups. It's when they are in between the census." The staffing coordinator was not able to respond to the question.

During further review of 2 W Minimum Data Set (MDS) resident coded level of assistance it was revealed 43 residents in the entire unit which was over half required extensive physical assistance of two staff with bed mobility, transfers and toileting needs. In addition, the facility indicated

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{F 725}	Continued From page 23 10 residents required physical assistance with eating, 13 required mechanical transfers and 10 required mechanical stand lift.	{F 725}		
{F 761} SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store refrigerated medications between 36-46 degrees Fahrenheit (F) in 1 of 5 medication refrigerators. Additionally, the facility failed to remove expired eye	{F 761}	Expired eye medications were removed from the medication cart. Broken thermometer in the 2W refrigerator was replaced immediately.	1/24/19

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{F 761}	Continued From page 24 medication from medication storage on 1 of 5 medication carts located on second floor west unit. Findings include: On 1/3/19, at 10:21 a.m. licensed practical nurse (LPN)-A verified the second floor west medication refrigerator temperature was 22 degrees F. Review of the January log identified the refrigerator temperature was less than 36 degrees F., 3 of 3 days 1/1/19, 1/2/19, 1/3/19. LPN-A confirmed the medication refrigerator temperature log indicated the temperature was not kept within the allowable range (36-46 degrees F). Stored in the refrigerator were 1 Novolog flex pen and 13 Humalog flex pens with manufacturer recommendations to keep unused bottles, cartridges, and pens of insulin in the refrigerator (between 36°F and 46°F). Registered Nurse (RN)-A indicated she had just adjusted the refrigerator temperature and she would come back in an hour to recheck. At 11:55 a.m., LPN-A indicated the medication refrigerator temperature was 25 degrees F. and stated the nurse manager had put in a maintenance ticket to look at the refrigerator. During medication storage review the 2 west far south medication cart on 1/3/19, at 10:21 a.m. with LPN-A, the following medications were found to be expired: -R6 Latanoprost drops 0.0005% 1/4 full were not dated and had a last filled date of 7/31/18. LPN-A confirmed the medication was last administered on 1/2/19 in the evening and that R6 did not have another available bottle of Latanoprost. According to Drugs.com you must discard the bottle within six weeks after opening it if you choose to keep it	{F 761}	Medications carts were audited to verify expired medications have been removed. Refrigerators were audited to verify appropriate temperatures by administrative nursing staff. Current nursing staff will be re-educated and new nursing staff will be provided education on expired medications vs. discard dates and the proper monitoring of refrigerator temperatures by the director of education and/or administrative staff. 1 medication cart per unit will be audited weekly x 2 weeks, bi-weekly x 4 and monthly x 3 by nursing administration on medication carts to verify expired medications have been removed and refrigerator temperatures are accurate. Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x4, monthly x2, and quarterly.	

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{F 761}	Continued From page 25 at room temperature. During an interview on 1/3/19, at 1:31 p.m. the director of nursing (DON) stated the facility had replaced the thermometer in the refrigerator and if it was still below 36 degree F., the refrigerator would be replaced. The DON indicated it was her expectation to date eye drop bottles when opened and dispose of them prior to expiration. Review of the facility's Storage of medication policy revised April 2007, indicated "9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly."	{F 761}		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		1/24/19

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F 803	Continued From page 26 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate 1 of 1 resident (R701) dietary preferences. Findings include: R701's Care Area Assessment (CAA) assessment dated 11/27/18, included diagnoses of cerebrovascular accident and anemia. In addition, the CAA indicated R701 had intact cognition. R701's care plan revised on 11/26/18, indicated R701 received a regular diet. During an interview on 1/2/19, at 10:27 a.m. R701 stated that she preferred to eat hot foods and preferred not to eat sandwiches. During an observation on 1/2/19, at 1:06 p.m. nursing assistant (NA)-E was observed passing room trays to the 700 unit where R701 resided. At 2:10 p.m. R701 stated that she had been with the speech therapist and had not eaten lunch and it was "very late" as it was supposed to be here around noon. At 2:14 p.m. a NA entered R701's room and offered to assist her to bed. R701 stated, "I am waiting to eat my lunch I am hungry and I haven't eaten" and the NA stated, "I will go ask the kitchen." At 2:30 p.m. registered nurse (RN)-B returned from the kitchen with R701's	F 803	Registered Dietician interviewed R701 to review dietary preferences. The tray card was reviewed and updated for dietary preferences. The Food Services Staff will complete interviews of currents residents, whom are interviewable to obtain and updated likes and dislikes by 1/24/19. Likes and dislikes are updated in the tray card system. Additionally staff were made aware of the communication form to note likes and dislikes as the need arises. The Food Services staff will be re-educated on establishing and using a tray identification system to verify that each resident receives his/her preferences as ordered by 1/24/19. Dietary preferences will be reviewed with residents during care plan meetings by Interdisciplinary Team upon admission, quarterly, annually, and with significant change. Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance weekly x 4,	

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F 803	Continued From page 27 lunch tray and was unaware of why R701 had not eaten lunch earlier. At 2:58 p.m. R701 was observed eating a lettuce salad with ham, cheese and a hardboiled egg and a turkey sandwich. R701 stated she preferred hot food and did not like the sandwich, however, verbalized, "I will try to eat the sandwich I am hungry, I would be interested to know what the hot food choice was." During an interview on 1/3/19, at 7:22 a.m. R701's speech therapist confirmed she worked with R701 on 1/2/19, from approximately 1:00 p.m. to 1:50 p.m. and stated R701 should have eaten prior to their session. The speech therapist confirmed staff did not offer R701 her room tray during their session. During an interview on 1/3/19, at 7:25 a.m. the dietary manager stated the nursing staff would communicate with the kitchen when a resident had not eaten and a food option would be provided for them. The dietary manager further stated soup, toast, oatmeal, sandwich and salad were always available as options however, the lunch hot food item for the day would be disposed of by 1:15 p.m.. During an interview on 1/3/19, at 1:51 p.m. the director of nursing stated it was her expectation for staff assigned to the unit to ensure all residents have been served their meal during the designated meal time. The facility policy Therapeutic Diets revised March 2016, indicated, "5. The Food Services Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered." The facility policy Resident Food Services revised January	F 803	monthly x 2, and quarterly.	

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F 803	Continued From page 28 2019, indicated, "Menus reflect, based on the community ...as well as input received from residents and resident groups."	F 803		

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On January 31, 2019,

I, Diane Willette, Administrator, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated January 31, 2019 and issued to:

North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

The Penalty Assessments attached hereto have been corrected as of January 31, 2019.

Signed: Diane Willette, Administrator, Date 1-31-19
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On January 31, 2019,

I, Amy Charais, HFE TI, of the Division of
(Name)(Please Print) (Title)(Please Print)
Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated January 31, 2019 and issued to:

North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

The Notice of Penalty Assessment was handed to Diane Willette,
(Name)(Please Print)
Administrator, Date 1/31/19
(Title)(Please Print)

Signed: [signature], HFE TI, Date 1/31/19
(Name)(Please Print) (Title)(Please Print)

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

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS
FOR NURSING HOMES

Hand Delivered on January 31, 2019.

January 31, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: Project # S5183030, H5183168, H5183170, H5183171, H5183172, H5183173, H5183156,

Dear Administrator:

On January 4, 2019, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 8, 2018 with orders received by you electronically on November 29, 2018.

State licensing orders issued pursuant to the last survey completed on November 8, 2018 and found corrected at the time of this January 4, 2019 revisit:

20265 - MN Rule 4658.0085 -- Notification of Change in Resident Health Status
20505 - MN Rule 4658.0300 Subp. 1 A-E -- Use of Restraints
20555 - MN Rule 4658.0405 Subp. 1 -- Comprehensive Plan of Care; Development
20830 - MN Rule 4658.0520 Subp. 1 -- Adequate and Proper Nursing Care; General
20895 - MN Rule 4658.0525 Subp. 2 B -- Rehab - Range of Motion
20910 - MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence
21015 - MN Rule 4658.0610 Subp. 7 -- Dietary Staff Requirements - Sanitiary Conditions
21426 - MN Rule 144A.04 Subp. 3 -- Tuberculosis Prevention and Control
21435 - MN Rule 4658.0900 Subp. A -- Activity and Recretion Program; General
21800 - MN Rule 144.651 Subp. 4 -- Patients & Residents of Health Care Facilities Bill of Rights

State licensing orders issued pursuant to the last survey completed on November 8, 2018, found not corrected at the time of this January 4, 2019 revisit and subject to penalty assessment are as follows:

20800 - MN Rule 4658.0510 Subp. 1 -- Nursing Personnel; Staffing Requirements	$300.00
20850 - MN Rule 4658.0520 Subp. 2 D -- Adequate And Proper Nursing Care; Shaving	$350.00
20900 - MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers	$350.00
21610 - MN Rule 4658.1340 Subp. 1 -- Medicine Cabinet And Preparation Area;storage	$300.00

21695 - MN Rule 4658.1415 Subp. 4 -- Plant Housekeeping, Operation, & Maintenance $200.00

The details of the violations noted at the time of this revisit completed on January 4, 2019 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1500.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Shellae Dietrich, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: ______ B. WING ______	R-C **01/04/2019**

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{2 000}	Initial Comments	{2 000}		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
On 1/2/19, through 1/4/19, surveyors of this Department's staff re-visited the above provider and the following correction orders are issued. The facility was found NOT to have corrected one or more correction orders issued as a result of the survey exited on 11/8/18. The uncorrected orders will remain in effect and will be reviewed at

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{2 000}	Continued From page 1 the next site visit. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. H5183172: On 11/8/18, an investigation of this complaint was completed. The complaint was substantiated at MN Rule 4658.1415 Subp 4. During the revisit, H5183172 was not corrected and reissued at MN Rule 4658.1415 Subd 4. H5183173: On 11/8/18, an investigation of this complaint was completed. The complaint was substantiated at MN Rule 4658.0085, MN Rule 4658.0520 Subp 2D, MN Rule 4658.0525 Subp 3, MN Rule 4658.0525 Subp 5A. B and MN Rule 4658.0510 Subp 1. During the revisit H518173 was not corrected and reissued at 483.25(b) Skin Integrity, §483.25(b)(1) Pressure ulcers and 4658.0510 Subpart 1. Staffing requirements. H5183174: At the time of the revisit survey, investigation of this complaint was completed and substantiated at MN Rule 4658.0520 Sup 1. H5183175: At the time of the revisit, investigation	{2 000}		

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{2 000}	Continued From page 2 of this complaint was completed and substantiated at MN Rule 4658.0520 Subp 2D. H5183176: At the time of the revisit, investigation of this complaint was completed and found to be un-unsubstantiated.	{2 000}		
{2 800}	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original order issued on 12/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement accommodation of needs, with timely assistance, for personal cares according to the residents' assessed needs and as directed by the care plan. This practice had the potential to affect all residents residing on the 2 W unit. Findings include: Refer to F686: The facility failed to ensure 2 of 3	{2 800}	Corrected.	1/24/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 800}	Continued From page 3	{2 800}		

residents (R28, R143) identified at risk for pressure ulcers received timely repositioning. The failure of the facility to implement interventions resulted in actual harm for R28 whose pressure ulcer worsened.

Staff interviews:
On 1/2/19, at 10:06 a.m. nursing assistant (NA)-C stated staffing was still a concern and times staff was being cut with low census and the management did not pay attention to the care level of the residents including those that needed two assist with transfers and 2 with cares, "It's not about the number it's the care level. They can cut but they need to look at the care level."

On 1/2/19, at 10:13 a.m. NA-D stated staffing had not gotten any better and this was a facility wide concern that staff were being cut without looking at the care needs of the residents, "sometimes the teams are split."

On 1/4/19, at 9:58 a.m. when NA-G stated, "We don't have enough people, we only have three aides" and "our brakes are taken out of our checks but we don't get them." When asked why R28 was not repositioned timely according to the care plan.

On 1/4/18, at 1:07 p.m. NA-A stated, "We don't have enough staff to reposition our residents on time" when asked why R28 was not repositioned timely according to the care plan.

On 1/4/19, at 11:33 a.m. NA-A stated she was not aware R143 wasn't repositioned on time and stated, "We are swamped, we don't have time."

Record review:
On 1/4/19, at 1:04 p.m. during a review of

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randomly selected staff schedules and staffing posting with the staffing coordinator, administrator and the human resource director the following was revealed on four of seven days selected:

-12/31/18, for the evening shift which started at 2:00 p.m. to 10:00 p.m. one nursing assistant (NA) on 1 SW and one NA on 2 West schedules had instead worked 3:00 p.m. to 9:00 p.m. In addition, one NA on 3 West had left early but it was not identified how early.

-12/29/18, for the evening shift 3 W schedule revealed one NA had a no call no show (NCNS) which was never replaced.

-12/28/18, for the day shift on 1 SW schedule revealed one NA had come in late for the 6:00 a.m. to 2:00 p.m. and one NA only worked 2:00 p.m. to 7:00 p.m. instead of 2:00 p.m. to 10:00 p.m.

-12/23/18, for the day shift in the Transitional Care Unit (TCU) a 6:00 a.m. to 2:30 p.m. nurse was floated to 2 W and the schedule indicated "Group 8 Nurse will work as Nurse and CNA." In addition, the same TCU unit had one NA NCNS which was never replaced.

During the review, the staffing coordinator verified on days staff had NCNS's no staff was found to replace them. When asked what the staffing pattern for 2 W was the staffing coordinator stated the unit was staffed with 4 nurses and 6 NAs at current average census of 66-68. When asked if the acuity, the level of assistance residents needed such as transfer level, repositioning assistance and other care needs which required more than one staff assistance, the staffing coordinator was not able to respond.

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{2 800}	Continued From page 5 When asked how she determined the staffing pattern for the facility the staffing coordinator stated it was determined by the director of nursing and the administration team. The staffing coordinator stated admissions and discharges were communicated throughout the day to determine staffing needs for the facility. When asked what happened when the census was low, the staffing coordinator stated when significantly low the facility flexed down. At 1:24 p.m. when asked if staff had brought complaints of insufficient staffing to her, the staffing coordinator stated, "Occasionally on TCU when census is in flex they say they don't know how to divide the groups. It's when they are in between the census." The staffing coordinator was not able to respond to the question. During further review of 2 W Minimum Data Set (MDS) resident coded level of assistance it was revealed 43 residents in the entire unit which was over half required extensive physical assistance of two staff with bed mobility, transfers and toileting needs. In addition, the facility indicated 10 residents required physical assistance with eating, 13 required mechanical transfers and 10 required mechanical stand lift.	{2 800}		
{2 850}	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed.	{2 850}		1/24/19

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{2 850}	Continued From page 6 This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original order issued on 12/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to ensure adequate grooming assistance for 1 of 3 residents (R62) reviewed for activities of daily living. Findings include: R62's annual Minimum Data Set (MDS) dated 11/16/18, indicated he was severely cognitively impaired and required assistance from staff for dressing and personal hygiene. During observation on 1/3/19, at approximately 12:15 p.m. R62 was seated in the dining room awaiting his noon meal. R62's face was unshaved and his pants were covered in what appeared to be food debris. During interview on 1/3/19, at 12:30 p.m. nursing assistant (NA)-E stated she had assisted R62 with cares that morning. NA-E stated she did not think R62's pants were dirty when she put them on him. NA-E further stated she attempted to shave R62 with an electric razor but he had refused. On 1/3/18, at 12:40 p.m. registered nurse (RN)-F stated R62 did not have an electric razor. She stated he used to but it had been missing for a while. RN-F stated staff should be using a disposable razor to shave him. At 2:23 p.m. RN-E stated R62 would change into his dirty clothes after the staff assisted him in the	{2 850}	Corrected.	

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{2 850}	Continued From page 7 morning. She stated his dirty clothes were kept in his closet even though she was aware of this behavior.	{2 850}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original order issued on 12/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to implement interventions to promote healing of pressure ulcers and prevent pressure ulcers for 2 of 3 residents (R28, R143) reviewed for pressure ulcers. This resulted in actual harm for R28 who's pressure ulcer worsened to a stage IV.	{2 900}	Corrected.	1/24/19

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Findings include:

R28's quarterly minimum data set (MDS) dated 11/9/18, indicated she was moderately cognitively impaired and required extensive assistance with bed mobility, transfers and toileting. The MDS further indicated R28 did not have a pressure ulcer. R28's care plan dated 12/11/18, identified a potential/actual impairment to skin integrity related to immobility and fragile skin. The care plan directed staff to lay R28 down after meals, document location, size and treatment of skin injuries and reminders to turn and reposition.

A facility Progress Note dated 9/5/18, indicated: pressure ulcer to coccyx noted on 9/3/18, "1/2x 0. .1 cm [centimeters]." R28 with new pressure wound to coccyx area to same spot where recent pressure wound healed. Area is compromised and at risk for recurrent injury given the current underweight status and poor appetite. Keep resident off wheel chair in between meals

During a continuous observation on 1/4/19, the following was observed: At 7:07 a.m. R28 was up seated in her wheel chair outside the nurses station. At 7:40 a.m. R28 was escorted to the dining room by staff where she remained until 9:52 a.m. At that time, staff escorted R28 to her room and placed her in front of the television without repositioning her.

On 1/4/19, at approximately 10:00 a.m. licensed practical nurse (LPN)-B stated he was aware R28 had a wound on the right side of her buttock but was not sure how long it had been there. LPN-B stated he did not usually work on that unit.

At 10:07 a.m. nursing assistant (NA)-A stated R28 was frail and had been having a lot of

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problems with her bottom. NA-A stated R28 was supposed to be repositioned every two hours and stated it had not been done since R28 had gotten out of bed that morning. NA-A stated she had not had time to reposition R28.

At 10:30 a.m. LPN-B and NA-A assisted R28 to lay down in her bed. R28 was noted to have a reddened area on her ischium approximately one inch round. LPN-B removed a dressing from R28's coccyx. LPN-B described R28's wound as approximately 5 cm x 4 cm with tunneling. The wound bed contained slough (dead tissue) and was described by LPN-B as a stage IV (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. pressure ulcer). LPN-B stated R28 also had a pressure ulcer on her shoulder that had been present for about a month.

R28's Nursing Weekly Skin Evaluations and Skin Condition Reports revealed the following:

12/12/18, Right gluteal fold maceration first observed on 9/5/18.
12/18/18, Skin condition dry, redness. No area identified.
12/25/18, Skin intact, no open areas.
12/26/18, right gluteal fold macerations. No measurements included.
1/1/19, Coccyx pressure ulcer unstageable measuring 1.5 cm x 2.2 cm. Wound bed eschar, surrounding tissue macerated.

The medical record lacked further documentation of the right gluteal fold and lacked documentation related to the shoulder.

Following the survey the provider submitted the

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following Progress Notes:

1/4/19, Progress Note written by LPN-B: Stage II (involve partial thickness skin loss involving epidermis, dermis, or both. The lesion is superficial and presents clinically as an abrasion, blister, or shallow center) pressure ulcer noted to back of left shoulder measuring .5 cm x .5 cm. Hospice nurse updated and said she was aware of the wound and indicated it had been only redness previously.

During interview on 1/4/19, at RN-A stated she was not aware R28 had a history of pressure ulcers to her coccyx and stated she was not aware of the pressure ulcer on her shoulder. RN-A stated the standard of practice for repositioning a resident with a pressure ulcer was every two hours and stated she expected the repositioning to be done according to the plan of care.

At 11:39 a.m. the director of nursing stated she expected staff to follow the plan of care and stated R28 should have been repositioned every two hours.

R143's quarterly MDS dated 12/24/18, indicated she had intact cognition, required extensive assistance from two staff for bed mobility, toileting and transfers and had a stage IV pressure ulcer. R143's care plan dated 10/2/18, identified bladder incontinence related to impaired mobility and a stage IV pressure ulcer to her coccyx. The care plan directed staff to encourage her to turn and reposition "at least" every two hours.

A care area assessment indicated R143 admitted to the facility with a pressure injury, healing stage IV and an area on her left heel. History of

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non-compliance with off loading and repositioning.

During continuous observation on 1/3/19, the following was observed: At 7:34 a.m. R143 was observed up in her wheel chair in her room. At 8:03 a.m. she was seated at a table in the dining room where she remained until 9:01 a.m. when she propelled herself to an adjoining activity room. At 9:35 a.m. R143 propelled herself to her room and sat in her wheel chair facing the window. At 9:52 a.m. a staff member entered the room to get a room tray and immediately left.

At 10:13 a.m. R143 remained seated in her wheel chair. R143 stated the staff only help her in the morning and at night. At 10:25 a.m., two hours and thirty nine minutes from the initial observation, RN-A and NA-F assisted R143 to stand using a mechanical device, after surveyor alerted RN-A of the last time R143 had been repositioned. R143 had a wound on her coccyx and two open areas on the right and left buttock. RN-A stated the the two areas on R143's buttock were new. The left buttock had a superficial open area approximately one inch. The right buttock was a superficial open area approximately two inches in length.

A Weekly Skin Condition Report dated 12/18/18, indicated R143 had a stage IV pressure ulcer on her coccyx measuring 2.0 cm x 1.3 cm x 1 cm..

A facility Progress Note date 1/3/19, following observation with surveyor indicated: Writer spoke to nurse practitioner about superficial open areas on left and right buttock. Nurses practitioner stated barrier cream should be applied and areas covered daily.

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{21610}	Continued From page 12	{21610}		
{21610}	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original order issued on 12/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to store refrigerated medications between 36-46 degrees Fahrenheit (F) in 1 of 5 medication refrigerators. Findings include: On 1/3/19, at 10:21 a.m. licensed practical nurse (LPN)-A verified the second floor west medication refrigerator temperature was 22 degrees F. Review of the January log identified the refrigerator temperature was less than 36 degrees F., 3 of 3 days 1/1/19, 1/2/19, 1/3/19. LPN-A confirmed the medication refrigerator temperature log indicated the temperature was not kept within the allowable range (36-46 degrees F). Stored in the refrigerator were 1 Novolog flex pen and 13 Humalog flex pens with manufacturer recommendations to keep unused bottles, cartridges, and pens of insulin in the refrigerator (between 36°F and 46°F). Registered Nurse (RN)-A indicated she had just adjusted the refrigerator temperature and she would come back in an hour to recheck. At 11:55 a.m., LPN-A	{21610}	Corrected.	1/24/19

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{21610}	Continued From page 13 indicated the medication refrigerator temperature was 25 degrees F. and stated the nurse manager had put in a maintenance ticket to look at the refrigerator. During an interview on 1/3/19, at 1:31 p.m. the director of nursing (DON) stated the facility had replaced the thermometer in the refrigerator and if it was still below 36 degree F., the refrigerator would be replaced. The DON indicated it was her expectation to date eye drop bottles when opened and dispose of them prior to expiration. Review of the facility's Storage of medication policy revised April 2007, indicated "9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly."	{21610}		
{21695}	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original order issued on 12/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document	{21695}	Corrected.	1/24/19

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review, the facility failed to ensure 3 of 3 residents (R95, R703, R704) wheelchairs were kept clean. In addition, failed to ensure rooms were kept clean for 1 of 1 resident (R16) with respiratory concerns.

Findings include:

R95's diagnoses included cerebral palsy, muscle weakness, profound intellectual disability and scoliosis obtained from the quarterly Minimum Data Set (MDS) dated 12/1/18. In addition, the MDS indicated R95 had severely impaired cognition, required total dependence of two staff with transfers, one assist with locomotion in the unit, used a wheelchair (w/c) and had functional limitation to both lower extremities.

R95's care plan dated 8/20/18, indicated R95 had limited physical mobility related to cerebral palsy and profound mental disability. The care plan indicated R95 used a wheelchair for locomotion and staff propelled her to specific destinations. In addition, the care plan indicated for transfers R95 required assist of two to transfer from bed to w/c.

On 1/2/19, at 1:42 p.m. R95 was observed lying in bed and her specialized wheelchair (w/c) was observed parked at the base of the bed. The w/c was observed to be heavily soiled with whitish and brownish multiple food spills on the w/c frame.

On 1/3/19, at 8:43 a.m. R95 was observed to be all dressed for the day and was seated on the w/c by the nursing station as multiple staff went by, however, none acknowledged the w/c needed to be cleaned.

On 1/3/19, at 9:00 a.m. to 9:22 a.m. registered

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nurse (RN)-A assisted R95 with breakfast. During the observation R95's w/c was observed soiled. At 9:23 a.m. RN-A was observed to wheel R95 to her room.

On 1/3/19, at 9:38 a.m. the director of maintenance stated wheelchair cleaning was done by the security staff at night and at times the maintenance staff cleaned them in the evening. When asked how his department was notified of soiled w/c's when it was not the scheduled time to be cleaned, the director of maintenance stated nursing staff would notify his department and when he got any notification he would pull and cleaned the w/c immediately.
-At 9:42 a.m. the director of maintenance reviewed the monthly wheelchair log and verified R95's w/c was last cleaned the first week in December 2018.
-At 9:46 a.m. the director of maintenance verified the w/c was soiled, "it is dirty for sure. I talked to the nurse couple of times about cleaning it but don't have documentation for it because we have been having problems having access to it to be cleaned. I did not talk to [security staff] why it was not done at night as he comes at 11:00 p.m. I need to coordinate with nursing when is a good time to have it cleaned maybe when she is getting a shower. The wheelchair needs to be taken down to the machine to be cleaned because it is dirty."

The undated facility Wheelchair Cleaning policy directed staff wheelchairs were to be washed monthly following the wheelchair washing schedule and as needed. In addition, the policy directed nursing staff to wipe down wheelchairs for spills and debris and for excessively soiled wheelchairs the staff was to put in "TELs" for maintenance to clean through the wheelchair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: ___ B. WING ___	R-C **01/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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) COMPLETE DATE
{21695}	Continued From page 16	{21695}		

machine.

R703 was observed on 1/2/19, at 1:19 p.m. seated in a tilt in space wheelchair. The left foot rest of the chair was hanging off to the side of the chair. Staff adjusted the foot rest, however, the foot rest did not stay in place causing R703's foot to dangle in the air. The left foot pedal did not match the one on the right side of the chair. R703's wheelchair was covered with food debris on the cushion, arm rests and wheels.

A Progress Note dated 11/21/18, indicated R703 transferred from another unit and indicated: foot rest on residents wheelchair was broken.

R704 was observed on 1/3/19, at 11:47 a.m. and R704's wheel chair was noted to be covered in food debris and had a substance all over the wheels of the chair.

During interview on 1/3/19, at 11:40 a.m. licensed practical nurse (LPN)-C stated the resident wheelchairs were supposed to be cleaned on the night shift. She stated R703's chair should have been cleaned on 12/30/18. LPN-C further stated she had completed a work order for the broken foot rest on R703's chair.

At 11:47 a.m. RN-E stated a wheelchair cleaning schedule was posted on the wall at the nurses station. RN-E stated there had been a breakdown in communication and felt it was on the night shift.

R16 was admitted to the facility on 7/26/18, and had diagnoses including acute and chronic

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	00238	A. BUILDING: ______ B. WING ______	R-C 01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

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{21695}	Continued From page 17	{21695}		

respiratory failure with hypoxia and chronic obstructive pulmonary disease. R16's brief interview for mental status (BIMS) score was 15 (13-15 indicates intact cognition).

R16's room was observed on 1/3/19, at 9:20. The heater/radiator fan, located underneath the window sill, was full of dirt and debris. The fan blew out cold air. The housekeeper went into R16's room at 9:25 a.m. after the housekeeper left the room (approximately 9:40 a.m.), the fan was still dirty and full of debris.

R16 was interviewed on 1/3/19, at 1:29 p.m. and said she washed 2 of the 7 vent panels of the fan herself. During the time of the interview, the fan blew out cold air. Dust debris was noted on the back of the closet door that was closest to the fan. A continuous positive airway pressure (C-PAP) machine (a machine that is a constant flow of airway pressure to the throat and ensures the airway stays open during sleep) was approximately 8 feet away from the fan, also had dust and debris on it. R16 indicated she had breathing problems and used oxygen and the C-PAP machine at night.

Maintenance staff-C was interviewed on 1/3/19, at 1:43 p.m. and indicated the fan needed to be cleaned and was last cleaned in the summer. Maintenance staff-C said the fans were cleaned twice a year.

An environmental tour was done with the maintenance director on 1/4/19, at 9:30 a.m.. The maintenance director said the fans are on a schedule to be cleaned once a month and housekeeping staff also cleaned the fans.

The housekeeping director was interviewed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: ______ B. WING ______	R-C 01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

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{21695}	Continued From page 18 1/4/19, at 11:43 a.m. and said housekeeping staff cleaned the top of the heat registers/fans. Housekeeping staff did general cleaning to a room each day and did a deep cleaning of one room each day. There were 18 rooms on R16's unit and the housekeeping director indicated that every 18 days each room would receive a deep clean. Number 6 of the daily deep clean check off list included: clean and wipe done heater/radiator units/tear apart to clean and vacuum filter and clean floor underneath.	{21695}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WOFB
Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245183**

2. STATE VENDOR OR MEDICAID NO. (L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

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) **01/01/2014**

6. DATE OF SURVEY **11/08/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12. Total Facility Beds **320** (L18)

13. Total Certified Beds **320** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(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: Amy Charais, HFE NE II — Date: 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Douglas Larson, Enforcement Specialist — Date: 12/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **05/01/1972** (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. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

November 29, 2018

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number S5183030, H5183168, H5183170, H5183171, H5183172, H5183173, H5183156, H5183160, H5183161, H5183162, H5183163, H5183164, H5183165, H5183166, and H5183167

NOTE: The Life Safety Code (LSC) survey findings will be processed in a separate enforcement letter.

Dear Administrator:

On August 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 27, 2018. (42 CFR 488.422)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 29, 2018. (42 CFR 488.417 (a))

Also, we notified you in our letter of August 22, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 29, 2018.

On October 5, 2018, we informed you that the following enforcement remedy was recommended to the CMS Region V Office:

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

On November 8, 2018, a standard survey was completed at your facility by the Minnesota Department of Health 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 8, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5183172 and H5183173 that were found to be substantiated. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby significant corrections are required. In addition, at the time of the November 8, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5183168, H5183170, and H5183171 that were

found to be unsubstantiated.

REMEDIES

As a result of the survey findings, the previously imposed remedies of state monitoring and discretionary denial of payment (42 CFR 488.417 (a)) will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following remedy:

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

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.

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, from the standard survey completed November 8, 2018), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the abbreviated standard surveys completed August 10, 2018, September 13, 2018, and October 18, 2018), i.e., the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

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 PoC 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 if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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 February 10, 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING ______ B. WING ______	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 11/4/18 through 11/8/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On November 4th through November 8th ,a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Along with the recertification survey, complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint, H5183168 was completed. The complaint was unsubstantiated.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 An investigation of complaint, H5183170 was completed. The complaint was unsubstantiated. An investigation of complaint, H5183171 was completed. The complaint was unsubstantiated. An investigation of complaint, H5183172 was completed. The complaint was substantiated at F584. An investigation of complaint, H5183173 was completed. The complaint was substantiated at F580, F677, F686, F690 and F725.	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. 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	F 550		12/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH** **NEW HOPE, MN 55428**

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F 550	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R175) reviewed for dignity concerns was provided privacy in public areas of the facility. In addition, failed to provide a dignified dining experience for 1 of 4 residents (R95) reviewed for dining. Findings include: R175's diagnoses included depression, schizophrenia and muscle weakness obtained from the quarterly Minimum Data Set (MDS) dated 10/5/18. In addition, the MDS indicated R175 required extensive assist of one to two staff for activities of daily living (ADL's) including getting dressed and personal hygiene. The MDS	F 550	The statements made on this plan of correction are not an admission to nor constitutes an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with the State and Federal regulation, this community will take the actions set forth in this plan of correction. F550 ¿ R175 was provided privacy to ensure dignity in public areas. R95 food is not being mixed together to ensure dignity.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 550	Continued From page 3 also indicated R175 had not rejected cares. R175's care plan dated 10/9/18, identified dependence on staff for assistance with all cares related to cognitive deficits and directed staff to "Assist with adjusting clothing/blanket if [R175] midriff is exposed." On 11/4/18, at 5:23 p.m. R175 was observed sitting in a wheelchair at the dining room table with her shirt over her head. R175's bare breasts were hanging out of the bra exposed to other residents, staff and visitors. During the observation nursing assistant (NA)-G was sitting across from R175 watching television, but did not cover R175 until surveyor questioned her. During the observation there were nine residents in the small dining room including two male resident's right across the table from R175. On 11/4/18, at 6:37 p.m. R175 was observed seated in her wheelchair by the nursing station. Her shirt was observed over her head and her bare breasts were exposed again. At this time NA-H approached R175 from the front then went behind her and wheeled her down the hallway with her breast exposed to the back nursing station which was approximately 200 meters. As NA-H parked R175 four other residents were observed in the area and looked at R175. NA-H then stated to NA-I "who put this on this woman. I brought her here so you can get her ready." At 6:40 p.m. NA-I approached R175 and adjusted the shirt over the head as he wheeled R175 to her room. At 7:09 p.m. when asked about the observation NA-H stated he had noticed R175's breasts were	F 550	Current residents that are assisted with meals and dressing have the potential to be affected by this alleged deficiency. Current staff was re-educated regarding resident rights including maintaining dignity when providing assistance with dining and dressing. DON or designee will complete audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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	245183	A. BUILDING ______ B. WING ______	C 11/08/2018

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F 550	Continued From page 4	F 550		

exposed and that was why he wheeled her out of the area to the unit. When asked if he should have covered her up NA-H stated he was not assigned to R175 and that was why he had brought her back to the unit for NA-I to put her to bed.

On 11/6/18, at 2:09 p.m. registered nurse (RN)-I stated he would expect the staff to redirect, divert and fix the problem as this was not dignified to leave R175 in that manner.

On 11/6/18, at 2:49 p.m. the director of nursing stated "first of all, residents belong to all staff here. The staff should have covered her and removed her from the area. That was not dignified of staff to do that."

Dignified dining experience:

R95's significant change MDS dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance to eat. R95's care plan dated 10/1/18, identified a self care deficit and indicated she could eat some finger foods independently when staff handed them to her and directed staff to feed all other foods.

Review of a facility Progress Note dated 11/5/18, indicated R95's intake had previously been excellent, however had been lower recently. As R95 was unable to communicate, unsure why intake was now 0-25%.

During observation on 11/8/18, at 12:43 p.m. R95 was seated in the dining room with staff assisting her to eat mashed potatoes and gravy

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F 550	Continued From page 5 and pureed quiche. R95 was reaching for things on the table and nursing assistant (NA)- J was moving items out of her reach. At 12:45 p.m. NA-J assisted R95 to drink a small sip of juice. R95 continued to reach for the cup and NA-J kept placing the cup out of R95's reach. NA-J then used a spoon to mix all of R95's food together on her plate. R95 was still reaching for her juice and NA-J continued to move it out of her reach. NA-J fed R95 a spoon full of the mixed together food. When NA-J attempted to feed R95 a second spoonful, R95 turned her head away. At 12:48, NA-J moved R95 away from the table without offering her anymore food or fluids. During interview on 11/8/18, at 12:52 p.m. registered nurse (RN)-A observed the food mixture on R95's plate. RN-A stated it was "100% not ok to mix food together." RN-A further stated R95 should have been offered more fluids before leaving the table. At 12:53 p.m. NA-J indicated she did not see a problem with mixing R95's food together and stated she mixed up all her own food when she ate. NA-J stated R95 was not able to tell her if she wanted all of her food mixed together. When asked about the fluids, NA-J responded, "I gave her some juice."	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		12/18/18

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F 558	Continued From page 6 other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was within reach for 1 of 1 resident (R117) reviewed during the initial survey sample for call light use. Findings include: R117's diagnoses included Parkinson's disease, history of falling, muscle weakness and difficulty walking obtained from the care plan revised 7/12/18. In addition, the care plan identified R117 was at risk for falls related to history of falls, impaired balance, Parkinson's disease and poor judgement. The care plan directed staff to keep the call light within reach and encourage R117 to use it when he had a need. On 11/4/18, at 1:27 p.m. during the initial screening process R117 was observed lying on his back in bed. R117 was observed holding a piece of meat in his hands and stated he had just finished his lunch but was chewing on the meat. R117 requested this surveyor to hand him a cup of coffee that was on top of the bedside table which was not within reach. When asked if he had used the call light resident stated he did, but did not have one. When surveyor attempted to find the call light the holding mount on the wall was observed with no call light next to bed. As surveyor was exiting the room a call light unit and cord were observed on top of the bedside dresser by the first bed which was located by the door. On 11/4/18, at 1:36 p.m. nursing assistant	F 558	F558 R117 call light was placed within reach. Current residents have the potential to be affected by this alleged deficiency. Current staff were re-educated on placing call lights within reach. DON or designee will complete call light observation audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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F 558	Continued From page 7 (NA)-F came to R117's room and verified R117 did not have any call light on the wall mount by his bed. NA-F stated all residents were supposed to have a call light in reach if they were able to use it to summon staff for assistance. When asked if he was able to connect the other call light unit by the first bed NA-F stated he did not know how but was going to have the nurse put a work order for the maintenance department to fix it. NA-F left the room and returned with licensed practical nurse (LPN)-D who stated when they were in the room assisting R117 the call light was in reach. LPN-D thought housekeeping staff had been in the room and moved the call light. When asked when she had been in the room, LPN-D was not able to state. LPN-D stated all residents who were able to use their call lights were supposed to have the call lights in reach at all times to call for assistance LPN-D stated R117 was at risk for falls. On 11/8/18, at 11:50 a.m. the director of nursing stated all the call lights were supposed to be within reach at all times when a resident was in the room and was able to use it. The facility Answering the Call Light policy revised October 2010, directed staff: "4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident ..."	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		12/18/18

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

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F 580	Continued From page 9 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify a resident representative of a significant weight loss for 1 of 3 residents (R31) reviewed for nutrition. Findings include: R31's diagnoses included dysphasia, aphasia, dementia, hemiplegia, diabetes mellitus type II and anemia obtained from the quarterly Minimum Data Set (MDS) dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required total dependence on staff with eating. R31's care plan revised 8/7/18, indicated R31 was at increased risk for nutrition related to a self "feeding" deficit, an altered diet and had a significant unplanned weight loss. The care plan directed staff to encourage family involvement and identified FM-A as the appointed health care agent due to R31's inability to communicate and make decisions for himself. On 11/5/18, at 10:15 a.m. when asked if R31 had lost weight, family member (FM)-A stated "they don't feed him and he has lost weight. They put the water in the room but he is not assisted with it because he is not physically able to do it."	F 580	F580 R31 representative has been notified regarding resident□s weight loss Current residents with significant weight loss have the potential for being affected by this alleged deficiency. Dietician staff and IDT team has been re-educated on notifying resident representative regarding significant weight loss. Dietary manager or designee will audit current residents with significant weight loss weekly x 4, then, monthly x 3 for notification. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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F 580	Continued From page 10 FM-A also stated when he and other family members visited R31, he always ate well and thought when the staff told him he refused., staff just need to be patient. FM-A further stated he had noticed the weight loss over time however facility staff had not reached out to him or other family members to discuss what could be done, nor was he aware of any interventions in place for the weight loss. On 11/6/18, from 8:18 a.m. to 8:32 a.m. R31 was seated at a table in the dining room waiting for breakfast. At 8:32 a.m. NA-D brought R31's plate of food, set it in front of R31 and left. At 8:36 a.m. NA-A came back to the table sat next to R31 and started to assist R31. At 8:43 a.m. NA-D left the table and went to the main dining room area. NA-D got two straws which she brought back for R31's beverages. At 8:53 a.m. after R31 ate a few bites of his food with sips of the juice, NA-D wheeled R31 out of the dining room and placed him by the nursing station. At 8:54 a.m. NA-D stated R31 had eaten approximately 25% with 10 milliliters of the cranberry juice. NA-D acknowledged she had not offered R31 anything else, as he did not want to eat. On 11/06/18, at 1:20 p.m. during a follow up interview FM-A stated he had not been notified of the significant weight loss. FM-A stated another family member had come to visit R31 during meal time and had found R31 was seated at the table with food in front of him and no staff present to assist him. During review of medical record it was revealed R31's significant weight loss had been identified and noted in progress notes by the dietician on 7/10/18, 8/14/18, 8/27/18, 9/4/18, and 11/1/18.	F 580		

F 580 Continued From page 11 F 580

The dietician had also indicated 8/14/18, due to the significant weight loss in 90 and 180 days a nutritional supplement was ordered. During further review it was revealed on 11/1/18, the dietician had again noted R31 had a unplanned weight loss of 17.3 pounds, 10.5% in 180 days. The medical record lacked documentation of R31's responsible party being informed of the weight loss.

On 11/6/18, at 12:56 p.m. the consultant registered dietician (CRD) stated R31 was on a nutritional supplement twice daily due to unplanned significant weight loss over the last 180 days and thought R31 had leveled off in the last 90 days. When asked if anyone in the dietary department had observed R31 during meals, the CRD stated she did not think so. When asked what staff were supposed to do when a resident did not eat well, she stated staff were supposed to offer an alternate and all residents were supposed to be offered enough fluids with meals. When asked who was supposed to notify family/responsible party of R31's significant weight loss, CRD stated she would have expected nursing to have notified the responsible party as she did not know how much the family was involved in R31's care.

On 11/7/18, at 8:46 a.m. registered dietician (RD) stated since the significant weight loss had been identified R31 had been started on the nutritional supplement and thought the weight had stabilized. When asked if anyone had watched R31 during meals, RD stated "No I'm fairly new and part-time." RD stated when he completed the assessments he would ask the aide or nurse how R31 ate. When asked who notified family/responsible party, RD thought

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F 580	Continued From page 12 during care conferences an RD would but otherwise nursing would be doing the update. At 9:42 a.m. the RD stated at the time the RD had written the telephone order for the nutritional supplement for weight loss on 8/15/18, when the nurse noted the order it was the responsibility of the nurse to have updated the family/responsible party about the weight loss. On 11/7/18, at 2:10 p.m. registered nurse (RN)-I reviewed the interdisciplinary notes and verified there was no documentation of family/responsible party being notified of the significant weight loss. RN-I stated he would have thought the RD was the one to do the notification since they were experts but also thought nursing would have done it due to the new order. On 11/7/18, at 2:26 p.m. the director of nursing stated she would have expected the dietary department to have notified the family or responsible representative of the weight loss when the supplement was initiated. The Change in a Resident's Condition or Status policy dated November 2017, directed staff "The facility staff shall promptly notify the resident, his or her attending physician and resident representative of changes in the resident's medical/mental condition and/or status..."	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		12/18/18

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F 584	Continued From page 13 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow up promptly on a concern of missing personal clothing items for	F 584	F584 R108 missing item report was completed	

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F 584	Continued From page 14 1 of 1 resident (R108) reviewed for personal property. In addition, failed to maintain an environment that was clean, free from odors and in good repair in rooms 132, 282, 390, 247, 338 and failed to assure wheel chairs were clean and free from debris for three residents (R31,R54, R103) who resided in the facility. Findings include: R108, on 11/4/18, at 4:44 p.m., family member (FM)-C was asked if R108 had any missing items, and stated they had brought R108 multiple pieces of clothing and all were missing. FM-C pointed to a list hanging on the closet door which stated "(Dropped OFF 10/15/17 to get labeled)." FM-C stated all the listed items which included: 10 pairs of socks, 6 sweat pants, 5 shirts, 4 t-shirts, 2 flannels, 1 pajama bottom and a pair of slippers were all missing. FM-C stated nothing had been done about the missing items despite the facility staff being aware of the issue. On 11/6/18, at 9:40 a.m. registered nurse (RN)-K and nursing assistant (NA)-E were observed assisting R108 to get dressed. During the observation NA-E and RN-K applied a black t-shirt which had a large tear on the chest exposing R108's chest. At 10:52 a.m. NA-E asked licensed practical nurse (LPN)-D to assist him to apply a light weight sweat shirt. During the observation none of the staff acknowledged R108's t-shirt was ripped. On 11/7/18, at 6:52 a.m. housekeeping/laundry staff stated when clothing needed to be labeled the staff was supposed to put the clothing in a	F 584	for missing clothing items. Repairs to rooms and equipment for 132, 282, 247, and 338 have been completed. R31 and R54 wheelchairs have been cleaned and are free of debris. . Room 390 has been cleaned and free from odors. R103 is no longer residing at North Ridge Current residents that have reported missing clothing items have the potential to be affected by the alleged deficiency. Current residents that have wheelchairs have the potential to be affected by this alleged deficiency. Current residents that are care planned hoarders have the potential to be affected by the alleged deficiency. Current staff have been re-educated to the location of the missing item report forms and the need to complete when missing items have been reported to them. Social Services, Nurse Managers, and Administration have been educated on policies and procedures for missing items. Current maintenance staff has been re-educated on the procedure for wheelchair cleaning. Current maintenance and housekeeping staff	

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F 584	Continued From page 15 bag with the resident name and she would come and collect them and have them labeled. Staff stated the resident family was very good at providing descriptions of the clothing and she would follow up. The housekeeping/laundry staff stated there was a chance the clothing was never marked and would be looking through the lost and found and would to try to find something about the clothes. At 7:38 a.m. the housekeeping/laundry staff stated all the listed items at the closet door went missing a couple of months after family had brought the clothes. She also stated anytime she was not able to find missing item(s) she would try to find it then would report to nursing and the floor social worker. She further stated she had reported to the former social worker several times that she had not been able to find the clothes and did not know the outcome. When surveyor told staff about the torn t-shirt R108 was wearing, she stated she had just gone through the closet and room and had seen R108 did not have clothing and she was going to go downstairs to find some donated items to give to R108 in the meantime. On 11/7/18, at 2:46 p.m. the director of social services (DSS) stated she was not aware of resident's missing clothing as previously there was another social worker assigned to the floor who had been following up on the concerns. The DSS stated she was going to find out and would follow up with surveyor. On 11/8/18, at 2:46 p.m. the administrator stated a missing item form was supposed to be	F 584	have been re-educated on the procedure for repairs and odors in resident rooms. Administration or designee will complete audits of up to 4 submitted missing item forms weekly x 4, then, monthly x 3. Maintenance and housekeeping or designee will complete 4 resident room audits for repairs and odors weekly x 4, then, monthly x 3. Maintenance will complete 4 resident wheelchair audits for cleanliness weekly x 4, then, monthly x 3. Administration or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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completed and staff were supposed to look in the room, check laundry and outsourced laundry then if the facility was not able to find the item(s) the facility was to replace them. The administrator further stated the item(s) could be replaced through a catalog or family could buy the items and a check would be issued to them. The administrator further stated after staff had searched for the items and were not able to locate them they were supposed to call the family or responsible party to discuss the missing item(s) progress and process. During the interview the assistant administrator verified R108's missing items were not on the list through October 2017. The administrator requested a copy of the missing items and stated she would follow up on the issue.

On 11/8/18, at 3:00 p.m. the policy for missing items was requested but was not provided.

Environment concerns:

During observation on 11/7/18, at 2:08 p.m. it was noted that room 132 had a musty mildew odor. A wall air/heating unit in the room was running.

In room 282 a feeding pump stand base was soiled with a light brown dried on substance. The same substance was observed on the carpet. In room 247 there were gouges in the sheet rock near the room door. In room 390 there were many boxes and bags stacked in the room. In addition there was a foul odor detected in the room. In room 338 there were gouges in the

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sheetrock, and R103, R31, and R54 had soiled wheelchairs.

On 11/8/18, at 9:42 a.m. the maintenance director (MD), environmental services director (ESD), and community relations/assistant administrator toured with the surveyor to interview about the observations noted on 11/7/18. In room 132 the maintenance director (MD) stated the heating units in the rooms were checked for mold and mildew. The MD stated the facility had a meter to check the air quality coming out of the heating units. The MD stated he would check the room with the meter after the tour.

In room 282 the ESD stated the stand and carpet are the responsibility of housekeeping to keep clean. The ESD called a housekeeper to the room to begin cleaning the feeding tube pump stand and carpet. In room 247 the MD stated the rooms were checked regularly for repair and painting needs. The MD stated no work order had been completed for that room. The MD stated when repairs were needed the staff should have filled out a work order and the maintenance department would get them completed as soon as possible. The ESD was shown R103's, R31's, and R54's wheelchairs and asked if there was a system for cleaning the wheelchairs. The ESD stated a system was being worked on, but she would get the housekeeper to clean the wheelchairs. Room 338 also had gouges in the wall. Again the MD stated he would do an inspection of all the rooms and make sure the walls were repaired and painted. In room 390 there was still a foul odor and the boxes and bags were cluttering the room. The

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F 584	Continued From page 18 ESD stated it was difficult to clean room 390 because the resident told the housekeepers to leave. The ESD stated she had not had a discussion with the social worker or interdisciplinary team to come up with a plan for cleaning room 390. At 11/8/18, at 11:23 a.m. the administrator stated the staff was expected to fill out a maintenance request on the computer when there were cleaning or maintenance needs in the building. The adminstrator added the staff were taught how to complete the maintenance requests during orientation. Review of the facility policy Work Orders, Maintenance dated 8/2014, indicated facility staff were responsible for completing a work order request and turning it into maintenance for completion.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 604		12/18/18

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includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to ensure residents were free from physical restraints for 1 of 2 residents (R82) reviewed for restraint use.

Findings include:

R82's quarterly Minimum Data Set dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance for transfers, toileting and bed mobility. R82's care plan dated 8/4/18, identified a self care deficit and limited physical mobility. The care plan directed supervision with ambulation. The care plan further identified a risk for falls and directed staff to place R95 in a geri-chair four hours per day after lunch.

During observation on 11/4/18, from 1:30 p.m. to

F 604

F604

R82 is free from physical restraints per facility policy.

Current residents in broda/reclining chairs have the potential to be affected by the alleged deficiency.

Current nursing staff were re-educated on the physical restraint policy and procedure.

DON or designee will complete restraint observation audit weekly x 4, then, monthly x 3 on residents with broda chairs. DON or designee will monitor weekly for compliance.

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F 604	Continued From page 20 4:30 p.m. R95 was lying in a reclining chair, leaning to her left side with her head resting on the armrest of the chair. R95 appeared to be asleep. On 11/5/18, at 8:21 a.m. R95 was asleep in a reclining chair in the television room outside the nurses station on the unit. A standard wheel chair was observed in R95's room. R95 remained in the reclining chair until 9:26 a.m. On 11/6/18, at 7:33 a.m. R95 was again lying in a blue reclining chair in the television room on the unit. R95 appeared to be asleep. She was leaning on her left side with her head lying on the arm rest of the chair. The chair was reclined all the way back. R95 still remained in the chair at 9:29 a.m. During interview on 11/6/18, at 9:37 a.m. registered nurse (RN)-M stated R95 was up a lot during the night. RN-M stated R95 had been falling a lot and had gotten the reclining chair a few months ago. RN-M stated staff put her in her bed at night but if she woke up they would place her in the reclining chair. She stated R95 slept in the chair almost every night, On 11/6/18, at 9:56 a.m. nursing assistant (NA)-C stated R95 wanted to get up by herself. NA-C stated R95 no longer walked with staff but still wanted to. NA-C stated the reclining chair kept R95 from getting up and stated if staff put her in the standard wheel chair she would try to get up and walk. NA-C stated R95 could get up from the regular chair but not the recliner, she stated "that's why we put her in it."	F 604	Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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At 10:03 a.m. NA-K stated when R95 started getting up from the regular wheel chair, staff put her in the recliner chair. NA-K further stated the staff did not attempt other things but just put her in the chair.

During interview on 11/6/18, at 1:34 p.m. RN-K stated R95 transferred herself a lot so they ordered her a reclining chair. She stated R95 had not fallen in a few weeks but stated she used to fall quite a bit, especially at night, RN-K stated she thought the nurse practitioner had ordered the chair for positioning. RN-K stated she was unable to say how often staff were using the reclining chair or how they were utilizing the chair. She further stated she did not know how often R95 was up at night in the chair but stated staff should not be getting her up to sleep in the chair at night.

During interview on 11/6/18, at 2:27 p.m. licensed practical nurse (LPN)-B stated R95 was a huge fall risk. LPN-B stated the p.m. shift washed R95 up and and dressed her for bed then put her in the recliner chair to sleep because she was a high fall risk. LPN-B stated she thought R95 had an order to sit in the recliner chair after lunch but not for bed. LPN-B stated she thought the night shift put her in bed but R95 would try to get up so they put her in the reclining chair.

At 2:10 p.m. the director of nursing stated staff should be using R95's reclining chair for positioning and she should not be sleeping in the chair at night.

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F 604	Continued From page 22 A facility policy titled Use of Physical Restraints dated September 2017, indicated restraints shall only be used for the safety and well-being of the resident. Restraints shall only be used to treat the residents medical symptoms and never for discipline or staff convenience or for the prevention of falls. Examples of devices that can be considered a restraint include placing a resident in a recliner that prevents them from rising.	F 604		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		12/18/18

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F 656	Continued From page 23 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 resident (R160) reviewed for behavioral concerns, and 1 of 1 resident (R11) using a full lift. Findings include: R160's admission Minimum Data Set (MDS) dated 9/30/18, indicated R160 was moderately cognitively impaired, demonstrated no mood or behavior symptoms and required extensive assistance with most activities of daily living (ADL's). Diagnoses included hemiplegia (paralysis that affects just one side of the body) and hemiparesis (weakness on half of the body)	F 656	F656 R160 behavior care plan reviewed and updated. R11 ADL care plan reviewed and updated. Current residents with behavioral concerns have the potential to be affected by this deficiency. Current residents with full lifts have the potential to be affected by this deficiency. CCC (clinical care coordinator), unit managers, and CRC (clinical	

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F 656	Continued From page 24 following unspecified cerebrovascular disease (stroke) affecting unspecified side, aphasia (loss of ability to understand or express speech), apraxia (inability to perform particular purposive actions), and compression of brain. The MDS indicated R160 was not receiving any scheduled or as needed (PRN) pain medications or any antipsychotic, antianxiety or antidepressant medications. Review of subsequent MDS assessments dated 10/7/18 and 10/21/18 indicated R160 exhibited no behaviors. Review of R160's plan of care, did not address any behaviors. Review of R160's Progress Notes indicated the following entries: 9/20/18, 10:42 p.m. Nursing: Note indicated R160 was alert, and confused. She was pulling out the Peg and pulled out the Catheter with 10 cc balloon. The Catheter was intact and no missing part was seen. R160 was pulling out the abdominal binder, clothing, falling out of bed and refusing cares. 9/21/18, 6:03 a.m. Nursing: Note indicated R160 did not sleep through the night,was pulling out the G tube and clothing through the shift. The note further indicated R160 had a floor bed and mattress for fall prevention. 9/21/18, 2:12 p.m. Nursing Note indicated R160 had been lethargic, sleepy from around 8:00 a.m. when she was given prn Zyprexa. She was agitated , trying to pull off her G-tube and wanted to roll over the bed. Family was present and seemed to suggest "...mom needed a rest"." 9/24/18, 5:31 a. m. Nursing: Note indicated R160 was restless all nigh, rolling on the floor mat and pulling on her G-tube. G-Tube intact	F 656	reimbursement coordinator) were re-educated on updating care plans for behavior concerns/interventions and full lifts. CRC or designee will complete care plan audits on residents with behavior concerns and full lifts weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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and placement check. Will continue to monitor.
9/24/18, 9:16 p.m.: Nursing Note indicated R160 was being monitored for readmission this shift, was resistive with cares, attempted to slap staff when giving cares. Staff unable to change tubing and assessed skin due to resistance.
10/8/18, 9:53 p.m. Nursing:Note indicated R160 was a bit agitated on shift, disconnected the feeding tube and also attempted to pull the G-tube out with her hands.
10/23/18, 6:29 a.m. Nursing Note indicated R160 was awake most hours of the night, at 3:44 a.m. writer and NAR went to assist her to bed, writer saw resident's catheter lying on the floor inflated.
10/23/18, 3:19 p.m. Nursing: Note indicated R160 refused to allow writer to re-insert her Foley catheter. Was very resistive.
11/4/18, 10:50 p.m. R160 started pulling catheter, taking out diapers, pulling G- tube, and messing herself. R160 was fighting with the staff while cleaning and using inappropriate words.

11/8/18, 10:18 a.m. Nursing Note indicated staff attempted foley catheter change but were unsuccessful due to patient being combative.

Observations on 11/4/18, at 1:30 p.m., R160 was lying naked on the bed in her room, yelling at the nursing assistant to leave the door open. Surveyor asked the staff if R160 required 1:1 supervision and the staff stated "not always but right now because she was trying to take out her tubing."

Interview on 11/6/18, at 8:00 a.m. speech therapist (ST)-A indicated on days R160 is

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fatigued she does not eat well, and does not like to be fed. ST-A indicated R160 would take food from staff, but would push the staff's hands away when the staff attempted to feed her.
During interview on 11/7/18, at 9:00 a.m.,with Registered Nurse (RN)-G, who complete MDS's, indicated she reviewed progress notes for very specific MDS items, and indicated R160 did not exhibit the specific behaviors. RN -G indicated if a resident started exhibiting behaviors between MDS assessments, then the nurse manager is responsible for updating the care plan.
On 11/7/18, at 9:15 a.m., RN-B verified R160 did not have any behaviors identified on the plan of care. RN-B stated R160 did exhibit behaviors.
On 11/7/18 at 9:23 a.m., Social Service (SS)-A indicated that nursing would add the specific behaviors to the plan of care.

R11 had a diagnosis of lymphedema and a left above the knee amputation of the left leg indicated on the current order sheet. A quarterly MDS dated 10/26/18 indicated R11 had intact cognition.

The care plan dated 10/26/18 indicated R11 had limited physical mobility and directed staff to use a hoyer lift (mechanical lift device), however, the type of sling was not indicated.

During observation on 11/5/18, at 9:09 a.m. a full lift cross legged sling was under R11 while seated in the wheelchair. R11 stated the staff lost the multipurpose (amputee) sling last Wednesday (10/31/18) and were not able to find another one. She stated she felt scared and the sling hurts her on the back of her leg on the right

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side when she was transferred in the cross legged sling. During the observation an instruction sheet for the multipurpose (amputee) sling was observed posted in the resident's room.

On 11/5/18, at 11:20 a.m. the nurse manager RN-A stated the multipurpose (amputee) sling should be used for R11 and this sling was ordered for her. He verified that the aide group 5 care sheet (undated) noted for R11 "hoyer" for transfers but did not specify the type of sling. He also verified the comprehensive care plan did not indicate the type of sling to be used.

A physical therapy assessment dated 10/19/18, indicated the staff was to use the multipurpose (amputee)sling and lift posted information for the staff to follow in R11's room.

During an interview with NA-A on 11/6/18, at 7:10 a.m., she stated she was told the sling for R11 had gone to the laundry and the other cross legged sling was to be used. She stated she was trained not to use a cross legged sling for amputee residents and did not know if it was decided by a nurse to use it. She verified the cross legged sling had been used since last Wednesday.

On 11/6/18, at 9:12 a.m. the director of nursing was interviewed and verified a cross legged sling should not be used for a full lift with a resident with an above the knee amputation. She stated the nurse should determine the type of sling and assure the resident was safely transferred in the full lift. She stated the care plan should reflect the assessed type of sling.

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F 656	Continued From page 28 The facility policy dated 10/2010, directed staff to review the resident care plan for special needs, and to use the needed equipment to safely transfer the resident.	F 656		
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 ensure adequate grooming was provided to 1 of 5 residents (R31) who was dependent on staff for activities of daily living (ADL's). Findings include: R31's diagnoses included aphasia, dementia and hemiplegia obtained from the quarterly Minimum Data Set (MDS) dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required physical extensive assistance of one to two staff to completed dressing and personal hygiene. R31's care plan dated 11/2/18, identified an self care deficit related to right hemiplegia, dementia and decreased mobility. The care plan directed staff to provide assistance of one staff for personal hygiene. On 11/4/18, 5:37 p.m. R31 was observed seated	F 677	F677 R31 has had adequate grooming. Current residents have the potential to be affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on the ADL policy and procedure. DON or designee will complete grooming audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	12/18/18

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F 677	Continued From page 29 in a wheelchair in the dining room and was noted to have scruffy facial hair. When greeted, R31 did not respond and looked away. On 11/5/18, at 9:53 a.m. R31 was observed outside the front nursing station. R31 was dressed and the scruffy facial hair remained. On 11/5/18, at 10:15 a.m. during a telephone interview family member (FM)-A stated staff did not make sure R31 had clean clothes and R31 was not shaved daily. FM-A stated when R31 was able to take care of himself he shaved daily and took pride in making sure he was well groomed, clean and " respected himself." On 11/6/18, at 1:20 p.m. FM-A was observed standing beside R31 in the television lounge area. R31 still had scruffy facial hair and dried food around his mouth. R31's shirt had both dried and wet food debris on it. FM-A stated he had just arrived at the facility to find R31 that way and was frustrated with the staff for not making sure R31 was well groomed and had clean clothing. FM-A stated the family had brought in a shaver but did not know where it was and if and when they shaved R31 as R31 was not well kept most of the time. On 11/6/18, at 2:29 p.m. registered nurse (RN)-K verified R31 was unshaved, had food around his mouth and the shirt on the front left side had dried and wet yellow food on it. RN-K stated she would have R31 cleaned up right away. RN-K further stated all residents were supposed to be assisted with cares and staff were to make sure residents were cleaned properly after meals and	F 677		

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F 677	Continued From page 30 were well groomed as she reminded staff all the time. On 11/7/18, at 2:26 p.m. the director of nursing stated residents were supposed to be provided cares as directed by the care plan and residents were supposed to be well groomed and have clean clothing.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide activity engagement for 1 of 1 resident (R82) reviewed during the survey. Findings include: R82's Activity Assessment dated 8/5/18, indicated it was very important to her that she participate in her favorite activities. The assessment identified activities of interest that included: religious services, group activities, music, books, newspapers, group activities and	F 679	F679 R82 will be provided with activity engagement that meets her interest / needs. Current residents have the potential to be affected by this alleged deficiency. Activity or TR Staff will review attendance records for current residents to assess that interest needs are being met.	12/18/18

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F 679 Continued From page 31
animals.

R82's quarterly minimum data set dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance for transfers, toileting and bed mobility. R82's care plan dated 8/4/18, indicated she was dependent on staff for activities. The care plan directed staff to escort R82 to activities and identified her preferences as nail care, special events, church and toddler time. The care plan indicated R82 enjoyed any kind of music.

R82's activity participation logs were reviewed and included the following activites:

8/7/18 to 8/31/18, R82 participated in 2 one to one activities, 2 group programs and one self directed activity.
9/1/18 to 9/30/18, R82 participated in 2 one to one activities, one group activity and one instance of watching television.
10/1/18 to 10/9, R82 had no documented activity attendance.
The activity attendance was requested through 11/8/18, but none provided after 10/9/18.
Review of the activity attendance lacked evidence R82 refused activity participation.

During observation on 11/4/18, from 1:30 p.m. to 4:30 p.m. R82 was lying in a reclining chair, leaning to her left side with her head resting on the armrest of the chair. R82 appeared to be asleep.

On 11/5/18, at 8:21 a.m. R82 was asleep in a reclining chair in the television room outside the

F 679

TR Director or designee provided re-education to Activity staff to review resident□s activity attendance for engagement of leisure to meet their interest / needs.

TR Director or designee will complete activity attendance audits weekly x 4, then, monthly x 3. Administrator or designee will monitor weekly for compliance.

Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement x 3 months.

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nurses station on the unit. R82 remained in the reclining chair until 9:26 a.m.

At 11:35 a.m. R82 was asleep in her wheel chair in the hallway outside the nurses station. At 1:29 p.m. she was asleep in a wheel chair in her room.

On 11/6/18, at 7:33 a.m. R82 was again lying in a blue reclining chair in the television room on the unit. R82 appeared to be asleep. She was leaning on her left side with her head lying on the arm rest of the chair. The chair was reclined all the way back. R82 still remained in the chair at 9:29 a.m.

At 1:09 p.m. R82 again was seated outside the nurses station alone.

On 11/7/18, at 6:50 a.m. a staff member directed R82 to remain seated in her chair. R82 replied, "I've ben sitting here ever since I got up." The staff member stated, "I know but I don't want you to fall."

On 11/7/18, at 6:24 a.m. R82 was seated in a wheel chair in the common area outside the nurses station. R82 stated, "I'll probably still be sitting just like this at supper time."

During interview on 11/6/18, at 1:11 p.m. registered nurse (RN)-M stated R82 did not really participate in activities unless it involved kids. She stated she usually just sits. RN-M stated R82 used to have a table in her room but she used it to stand so they got rid of it. She stated R82 liked to comb her hair and do her makeup

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F 679	Continued From page 33 and stated the table used to have those things on it. During interview on 11/6/18, at 2:27 p.m. licensed practical nurse (LPN)-B stated R82 didn't really do anything. She stated if asked about activities R82 would say no and stated once in a while she would go. LPN-B stated, "I think they don't take her because she would be a one to one." LPN-B stated R82 used to have a brown box in her room that contained items she used to comb her hair and fix her face. On 11/7/18, at 1:55 p.m. RN-K stated R82 liked to sit and comb her hair and stated she would comb it all day. RN-K stated usually R82 had a table in front of her. RN-K stated she did not know if R82's niece had taken the table home.	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 provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) for 1 of 1 resident (R108) reviewed for limitations in range	F 684	F684 R108 has been provided ROM during ADLs.	12/18/18

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F 684	Continued From page 34 of motion. Findings include: R108's diagnoses included left hand and wrist contracture, hemiplegia, muscle weakness and dementia obtained from the quarterly Minimum Data Set (MDS) dated 9/7/18. In addition, the MDS indicated R108 had functional limitation in range motion of one side on his upper and lower extremity. R108's care plan dated 9/1/18, indicated R108 had limited physical mobility related to a cerebrovascular accident (CVA) with left hemiplegia. The care plan directed staff to provide gentle ROM as tolerated with daily care. The care plan also indicated R108 frequently refused but staff were to attempt to provide the ROM to the left upper extremity, hand and wrist. The care plan further indicated R108 was to wear a palm protector in the left hand as tolerated and indicated it was okay to remove the palm protector for skin care, bathing and per R108's request. On 11/4/16, from 4:42 p.m. to 7:09 p.m. R108's left arm rested against his abdomen with the fingers of his left hand tightly clenched into a closed fist. There was no splint or rolled wash cloth in place in R108's left hand. When R108 was asked if he could open his hand and stretch out his fingers he stated it hurts. On 11/5/18, from 10:00 a.m. to 1:20 p.m. R108's left arm was observed resting on a armrest attached to the wheelchair. His left hand was	F 684	Current residents having limitations in range of motion have the potential to be affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on providing ROM during ADLs. DON or designee will complete ROM audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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F 684	Continued From page 35	F 684		

tightly clenched into a fist. There was no splint or rolled wash cloth in place in R108's left hand during the observation.

On 11/6/18, from 9:40 a.m. to 10:03 a.m. nursing assistant (NA)-E and registered nurse (RN)-K provided R108 morning care. They did not offer or provide ROM, nor was the palm protector applied to the left contracted hand. From 10:03 a.m. to 10:55 a.m. NA-E and licensed practical nurse (LPN)-D applied cream to R108's body, shaved him and applied a light sweat shirt but neither of them offered the hand palm protector for the left contracted hand nor offered passive ROM.

On 11/6/18, at 1:50 p.m. LPN-D verified the left hand palm protector had not been offered or applied to R108. LPN-D also verified she had signed it off on the treatment administration record as she thought NA-E had applied it. LPN-D then stated she was going to apply the palm proctor to R108's left contracture. At 1:58 p.m. NA-E approached R108 and applied the palm protector and R108 did not refuse.

-At 1:59 p.m. NA-E stated R108 was supposed to have the palm protector on the left contracted hand but he forgot to apply it that morning because he had a lot to do. NA-E further acknowledged he had not offered or completed ROM that shift.

-At 2:00 p.m. LPN-D stated NA-E was supposed to do passive ROM or at least offer and if R108 refused he was supposed to let her know.

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F 684	Continued From page 36 On 11/8/18, at 12:35 p.m. RN-I stated the NA's were supposed to complete ROM and apply the palm protector as directed by the care plan and the assignment sheet. Surveyor requested a copy of the ROM documentation/charting. On 11/8/18, at 4:30 p.m. no ROM documentation was provided. The Range of Motion Exercise policy revised October 2010, directed staff to document in the medical record the date, time, the type of ROM (active or passive) and how long the exercise was conducted.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 5 residents (R81, R31) identified at risk for pressure ulcers received timely repositioning. The	F 686	F686 R81 and R31 have been turned and repositioned per facility policy.	12/18/18

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F 686	Continued From page 37 failure of the facility to consistently implement a turning and positioning program resulted in actual harm, when R81 acquired three (3) new stage II pressure ulcers (partial-thickness loss of skin with exposed dermis). Findings include: R81 did not receive a position change on 11/7/18, for over three hours and acquired three new, stage II, pressure ulcers. R81's quarterly minimum data set (MDS) assessment dated 8/30/18, identified diagnoses including: dementia with Lewy bodies, Alzheimer's disease, muscle weakness neuromuscular dysfunction of bladder, and peripheral vascular disease. The MDS indicated R31 had severely impaired cognition and required physical assistance of two staff with toileting, bed mobility and transfers. The MDS further indicated R31 was frequently incontinent of cares, and had no refusal of care behaviors. R81's care plan dated 9/12/18, identified a risk for impaired skin integrity related to fragile skin and incontinence. The care plan indicated R81 had a history of a pressure ulcer on the coccyx and had a potential for pressure ulcer development related to immobility and incontinence. The care plan further indicated R81 had a stage 2 pressure ulcer to the coccyx and left buttocks. The care plan directed staff to assess and complete treatments to the pressure areas on the coccyx and left buttocks. The care plan directed staff to provide assistance with turning and repositioning at least every 2 hours	F 686	Current residents at risk for pressure ulcers (Braden <18) have the potential to be affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on turning and repositioning. DON or designee will complete repositioning audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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and more often as needed.

On 11/5/18, at 9:58 a.m. when asked if R81 had any pressure ulcers, family member (FM)-B stated "yes." FM-B also stated the pressure "sores" were on the buttocks, that R81 was not changed often enough, and that R81 was left to sit on her buttocks "for a long time."

During continuous observations on 11/7/18, from 6:25 a.m. to 9:54 a.m., the following observations were made: R81 was observed to lay on the backside in bed sleeping. At 7:50 a.m. nursing assistant (NA)-F went past R81's room but did not offer repositioning. At 9:40 a.m. R81 remained asleep on the backside with no attempts by staff to reposition (3 hours and 15 minutes), at which time the surveyor intervened and alerted licensed practical nurse (LPN)-E.

Nursing assistant (NA)-F was interviewed on 11/7/18 at 9:44 a.m. NA-F stated he did not know the last time R81 had been repositioned as he had come in late that morning. At 9:52 a.m., NA-F approached R81 and cued her they were going to check, change and reposition her. At 9:54 a.m. (3 hours and 29 minutes after last repositioning), NA-F and NA-M turned R81 to the left side. R81's incontinent pad was saturated with urine and three open bleeding areas were noted on R81's left lower buttock, with two other areas on the right buttock. In addition, a foam dressing was observed around the coccyx.

At 10:02 a.m. on 11/7/18, LPN-E was observed to remove the old dressing revealing an open area to the coccyx. LPN-E measured the three

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F 686	Continued From page 39 bleeding wounds and stated she was going to let the nurse manager know about them. LPN-E said in the meantime, she was going to apply a foam dressing until the physician could be contacted to obtain a treatment for the other open areas. At 10:05 a.m. LPN-E stated she would have expected R81 to have been turned and repositioned according to the care plan. She said if the NAs were not able to complete repositioning in a timely manner, they were supposed to let her know. During a follow up interview with NA-F at 10:30 a.m. on 11/7/18, NA-F stated he did not know he was assigned to R81 until the surveyor had asked about it. On 11/7/18, after concern was brought to the facility attention, a progress note dated 11/7/18, at 8:57 p.m. indicated the following:: "Resident noted with three new small stage 2 pressure wounds on the coccyx" The areas were measured as: 1.1 cm (centimeter) by 0.5 cm by 0.1 cm; 2.3 cm by 1.4 cm by 0.1 cm; and 1.1 cm by 0.8 cm by 0.1 cm; and one stage 2 wound on the left buttock measuring: 1.2 cm by 0.6 cm by 0.1 cm; and four small stage 2 pressure areas on the right buttock measuring 0.5 cm by 0.5 cm by 0.1 cm; 0.8 cm by 0.5 cm by 0.1 cm; 0.2 cm by 0.2 cm by 0.1 cm; and 0.3 cm by 0.2 cm by 0.1 cm. The note also indicated: "Resident also has a reddened blanchable area measuring 16 cm by 14 cm by 0.1 cm ..." During review of the Nursing Daily Pressure Injury Documentation dated 11/4/18, 11/2/18,	F 686		

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F 686	Continued From page 40 11/1/18, and 10/31/18, it was revealed that on all four dates the coccyx had been identified to have an open area. On 11/1/18, the assessment had indicated there was an open area on the left buttock. The documentation lacked staging, size, drainage color, odor and approximate amount, pain if present, nor did it include assessment of the wound bed to include the color and type of tissue/character and a description of wound edges and surrounding tissue. On 11/7/18, at 10:24 a.m. when asked about the wound documentation, registered nurse (RN)-K stated for the past few weeks the floor nurses had been doing the wound rounds for her. RN-K stated they were supposed to complete the documentation. RN-K verified the medical record lacked documentation related to staging, size, drainage color, odor and approximate amount, pain if present, wound bed including the color and type of tissue/character and a description of wound edges and surrounding tissue. On 11/7/18, at 1:56 p.m. RN-I stated he was not familiar with R81 however, after reviewing the care plan he stated the minimum expectation was R81 would be repositioned every two hours as she was at risk for pressure ulcers and already had a current pressure ulcer. On 11/7/18, at 2:02 p.m. RN-I reviewed the actual working schedule and verified R81 had been assigned to NA-F's team from the beginning of the shift. RN-I stated there was no reason NA-F should have been confused about being assigned to assist R81.	F 686		

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F 686	Continued From page 41 On 11/8/18, at 2:02 p.m. the director of nursing (DON) stated she had been at the facility for less than two months and was in the process of working on various care concerns. The DON stated wound assessments were something the clinical coordinators were working on as well as having the whole interdisciplinary team round. The DON further stated residents who were at risk for pressure ulcers were supposed to be repositioned at least every two hours or as directed by the care plan. The facility's Skin Integrity, Pressure Injuries, Nursing Protocol policy revised November 2017, indicated: "The resident will receive care, consistent with professional standards of practice to prevent pressure injuries and will not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and the resident with pressure injuries will receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing..." R31's quarterly MDS dated 8/8/18 indicated the resident had diagnoses including: aphasia, dementia and hemiplegia. The MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required total physical assistance of two staff with toileting, bed mobility and transfers. The MDS further identified R31 had not walked during the assessment period and was at risk for pressure ulcer development.	F 686		

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F 686	Continued From page 42	F 686		

R31's care plan dated 11/2/18, identified a risk for skin breakdown due to bladder and bowel incontinence, cognitive loss and decreased mobility. The care plan directed staff to offer repositioning every two hours and as needed.

On 11/7/18, R31 was continuously observed from 6:25 a.m. unit 11:34 a.m. (5 hours and 9 minutes). At 7:50 a.m. nursing assistant (NA)-F approached R31, tilted the wheelchair back and left R31 in the television lounge. At 8:41 a.m. the registered dietician (RD) wheeled R31 to the dining room table. R41 ate and was assisted directly to the main dining room for an activity where he remained until 11:20 a.m. when the surveyor intervened. At 11:20 a.m., NA-F stated when he came to the unit at 7:50 a.m. he had noticed R31 in the television lounge and had tilted the wheelchair back and at the same time had uncrossed R31's legs. When asked if that was an appropriate form of repositioning, NA-F stated it was and indicated it helped a resident change positions. NA-F stated he did not know when R31 had been repositioned last as the night shift had gotten him up. At 11:40 a.m., NA-F and NA-I were observed to use a mechanical lift to get R31 onto the bed. R31's brief was observed to be wet from urine.

On 11/7/18, at 2:02 p.m. registered nurse (RN)-I stated a resident had to have tissue relief of at least two minutes for it to be considered repositioning, which meant a resident had to be off- loaded from the surface. RN-I verified R31 was on an every two hour repositioning schedule and staff were supposed to follow the care plan.

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F 686	Continued From page 43 On 11/7/18, at 2:26 p.m. the DON stated residents who were at risk for pressure ulcers were supposed to be repositioned at least every two hours or as directed by the care plan. When asked what she considered to be appropriate repositioning, the DON stated a resident needed to be off- loaded from the surface.	F 686		
F 689 SS=E	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 provide therapeutic diets as ordered by the physician for 2 of 4 residents (R115, R83) reviewed for dining. In addition, The facility failed to utilize the appropriate mechanical lift sling for 1 of 2 residents (R11) reviewed for accidents. Findings include: R115's quarterly minimum data set (MDS) dated 9/4/18, indicated he was moderately cognitively impaired and required supervision while eating after meal set up. R115's care plan dated 10/2/18, indicated a potential nutrition/hydration problem related to a mechanically altered diet, coughing with meals and weight loss. R115's	F 689	F689 R11 has been provided with the appropriate mechanical lift slings. R115 and R83 have been provided the therapeutic diets as ordered by the physician. Current residents requiring mechanical lift slings have the potential to be affected by this alleged deficiency. Current residents with therapeutic diets have the potential to be affected by the alleged deficiency.	12/18/18

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F 689	Continued From page 44 Order Summary Report identified a physican's order dated 9/19/18, for a mechanical soft, ground texture diet with nectar thick liquids. R115, during observation on 11/4/18, at 5:24 p.m. R115 was in the dining room during the evening meal. R115, along with all other residents on a mechanical soft diet were served pureed food. During interview at 5:33 p.m. Dietary aide (DA)-A stated she was not sure what the residents on a mechanical soft diet could eat so she served them all pureed food. At 5:56 p.m. R115 received a meal of pureed food even though his diet slip identified a mechanical soft diet. R115 did not eat his meal. R83's quarterly MDS dated 6/31/18, indicated he was severely cognitively impaired and required supervision and physical assistance to eat. R83's Order Summary Report identified a physican's order dated 12/13/17, for a mechanical soft, chopped texture diet. The order indicated R83 may request regular texture meals and directed staff to cut meat into small pieces. R83's care plan dated 9/1/18, identified a dysphagia (difficulty in swallowing) diagnosis and a diet of mechanical soft food. During observation on 11/6/18, at 12:29 p.m. R83 was seated at a table in the dining room awaiting his noon meal. At 12:30 p.m. R83 requested a corn dog. DA-B served a corn dog, chopped up as directed by R83's diet. Nursing assistant (NA)-C returned the plate to DA-B and	F 689	Current licensed and certified nursing staff were re-educated on using appropriate mechanical lift slings. Dietary staff were re-educated on the Resident Rights Nutritional Care, policy and procedure. DON or designee will complete sling audits weekly x 4, then, monthly x 3. DON or designee will monitor for compliance weekly. Dietary manager or designee will audit 60 resident trays weekly x 4, then monthly x 3. Dietary manager or designee will monitor for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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F 689	Continued From page 45	F 689		

stated R83 would not eat the chopped up food and requested two whole corn dogs. She stated R83 would "get mad" if she served the chopped food. NA-C served the whole corn dogs to R83 and left the table.

During interview at 12:37 p.m. DA-B stated she gave R83 the right meal but NA-C told her to give him whole corn dogs so she did what NA-B asked.

At 12:38 p.m. NA-C stated R83 would not take the chopped up food, even though she had not offered it to him. She stated if she would have offered it, "it would have been a problem." She stated she thought the dietician knew about it.

At 12:40 p.m. registered nurse (RN)-K was alerted the wrong diet had been served. RN-K state the NA's were "absolutely" not allowed to upgrade a residents diet. She stated staff should be following the diet slip. RN-K did not remove the incorrect food consistency from R83.

During interview on 11/6/18, at 12:45 p.m. registered dietician (RD)-A stated nursing assistants were not allowed to upgrade a residents diet. RD-A reviewed R83's care plan and stated staff were to monitor for difficulty with chewing and swallowing. RD-A stated the care plan did not contain any modifications to R83's diet and did not contain any risks and benefits related to not following his prescribed diet. RD-A made no attempt to take the incorrect food from R83. When asked about the differences in the chopped and ground diets, RD-A stated if a resident was on a ground diet they could only

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have pureed bread.

R115, during observation on 11/7/18, at 8:44 a.m., was served eggs with cheese and regular toast. In addition, R115 was served thin liquids of milk and juice. R115 had eaten all of the toast and drank some of the milk and all of the juice, and was observed coughing at the table.

At 8:50 a.m. RN-I verified the incorrect diet had been served to R115. RN-I removed the remaining thin liquids. RN-I stated all staff in the dining room should be aware of the residents diet and were responsible to ensure the correct food was served.

During interview on 11/7/18, at 9:09 a.m. DA-B stated the aides tell her what they want her to serve and stated, "that;s what i give." When asked about the toast for a mechanical ground diet, DA-B stated, "pureed, I think. It's written here somewhere. Maybe you should ask the dietician."

During interview on 11/8/18, at 10:28 a.m. the director of dietary services (DDS) stated she had heard about the diet concerns on the third floor. The DDS stated staff received training related to food safety and diet and should know what food to serve. She stated the dietary aide should not give food that was not on the diet order. The DDS stated she rounded in the dining rooms during meal service but did not conduct any formal audits to ensure meals were provided as directed by the physicians order.

On 11/8/18, at 1:36 p.m. the director of nursing

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F 689	Continued From page 47 (DON) stated she had heard staff were giving incorrect diets. The DON stated nursing and dietary staff were responsible for ensuring the correct diet was served. A facility policy titled Accidents and Incidents - Investigating and Reporting dated April 2010, indicated all accidents or incidents involving residents, etc shalt be investigated and reported to the administrator. The nurse manager or supervisor shall promptly initiate and document investigation of the accident or incident. R11 had a diagnosis of lymphedema and a left above the knee amputation on the left leg. A quarterly minimum data assessment (MDS) dated 10/26/18 indicated a brief inventory of mental status (BIMS) of 15 which indicated R11 was cognitively intact for memory. The care plan dated 10/26/18 indicated R11 had limited physical mobility and directed staff to use a hoyer lift (mechanical lift device), the type of sling was not indicated. During observation on 11/5/18, at 9:09 a.m. a full lift cross legged sling was under R11 while seated in the wheelchair. R11 stated the staff lost the multipurpose (amputee) sling last Wednesday (10/31/18) and were not able to find another one. She stated she feels scared and the sling hurts her on the back of her leg on the right side when she was transferred in the cross legged sling. An instruction sheet for the multipurpose (amputee) sling was observed posted in the resident's room.	F 689		

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F 689	Continued From page 48 On 11/5/18, at 11:20 a.m. the nurse manager (RN-A) stated the multipurpose (amputee) sling should be used for R11 and this sling was ordered for her. RN-A was not aware that a cross legged sling was in use. RN-A verified that a cross-legged sling should not be used with a resident that had an above the knee amputation, and was not sure if the aides or a nurse had changed the sling. He verified that the aide group 5 care sheet (undated) noted for R11 "hoyer" for transfers but did not specify the type of sling. During an interview on 11/6/18. at 8:15 a.m., RN-A stated that nursing did not do an assessment for the type of sling to be used, that was done by the therapy department. A physical therapy assessment dated 10/19/18, indicated the staff was to use the multipurpose (amputee) sling and left posted information for the staff to follow in the resident's room. On 11/5/18, 11:15 a.m. during an interview with the education nurse, she stated nursing assistants (NA)'s were trained with the cross legged sling and not a cradle or amputee sling. She stated no training had been done with NA's about which sling was to be used, this would be the nurse's decision. During an observation on 11/5/18, at 2:38 p.m. a cradle full body sling was observed in the room. During an observation on 11/6/18, at 8:30 a.m., R11 was transferred by NA-A and NA-J in a full lift and a cross legged sling which had been under R11 in the wheelchair. R11 was transferred from the wheelchair to the bed as R11 was raised	F 689		

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up in the lift, R11 was off center and leaning to the left. The cross leg straps were in 2 different areas on her legs, and R11 complained of discomfort.

During an interview with NA- A on 11/6/18, at 7:10 a.m., she stated she was told that the sling for R11 had gone to the laundry and the other cross legged sling was to be used. She stated that she was trained not to use a cross legged sling for amputee residents and didn't know if it was decided by a nurse to use it. She verified that the cross legged sling had been in use since last Wednesday.

An interview with RN-A on 11/6/18, at 8:48 a.m. revealed that R11 was brought a cradle lift sling the day before and RN-A observed that the staff transferred R11 safely. RN-A was aware R11 now had the cross legged sling and it had been replaced on overnight shift because R11 requested.

Review of progress notes on 11/5/18, and 11/6/18, there was no note on change of sling, reassessment or notice to resident of the risks and benefits for the use of a cross legged sling. RN-A stated the risks and benefits of refusing the cradle sling were not documented yet .

On 11/6/18, at 9:12 a.m. the director of nursing was interviewed and verified that a cross legged sling should not be used for a full lift with a resident with an above the knee amputation. She stated the nurse should determine the type of sling and assure the resident was safely transferred in the full lift.

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F 689	Continued From page 50 The manufacturer's recommendations for use of slings for amputee residents included a multipurpose or hourglass sling. A multipurpose sling did not cross between the resident's legs. The facility policy dated 10/2010, directed staff to review the resident care plan for special needs, and to use the needed equipment to safely transfer the resident.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		12/18/18

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F 690	Continued From page 51 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting for 2 of 7 residents (R31, R81) reviewed for bowel and bladder. In addition, failed to ensure 1 of 7 residents (R224) received services and assistance to maintain bladder continence. Findings include: R224 Admission Record indicated she was admitted on 8/3/18, with diagnosis including weakness, essential hypertension, type 2 diabetes, morbid obesity, chronic atrial fibrillation, and major depressive disorder. Review of Minimum Date Set (MDS) dated 10/24/18, indicated R224 was frequently incontinent of bladder. Review of R224's plan of care dated 9/17/18, indicated R224 had "episodes of bladder and bowel incontinence", with interventions that included assisting her to the bathroom every two hours and as needed and to provide peri-care and management of pad/clothing.	F 690	F690 R31, R81, and R224 care plans and B&B assessments were reviewed and updated for current status. R31 and R81 were toileted timely per care plan. Current residents who are assessed as incontinent have the potential to be affected by this alleged deficiency. Current licensed and certified nursing staff were re-educated on timely toileting/incontinent care per care plans. Current licensed nursing staff were re-educated on the use of the 3 day voiding diary upon admission to determine continence pattern of new admissions. IDT were re-educated on the completion of the bladder assessment and resulting	

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F 690	Continued From page 52 Review of the Nursing 3 day voiding/ bowel movement evaluation dated 9/4/18, indicated "based upon the 3 day trial, is the resident continent. with the answer of yes," and that based upon the voiding diary, is the resident a candidate for : no retraining. Review of the Bladder Incontinence Evaluation dated 10/8/18, indicated R224 had urinary frequency that was not of recent onset. During interview on 11/05/18, at 1:30 p.m., R224 indicated she was continent of bladder at home with a small pad but after her catheter was removed in the facility, the staff told her to "go in her diaper" R224 indicated she had never been offered the commode or assistance into the bathroom and would tell the staff after she went to the bathroom in "her diaper." On 11/7/18, at 10:00 a.m., registered nurse (RN)-B indicated she would talk to R224 to see who had told her to "go in her diaper" and stated when a urinary catheter was discontinued, a three day assessment was completed and retraining should have been attempted, and verified R224 lacked retraining after the urinary catheter was removed. R31's diagnoses included aphasia, dementia and hemiplegia, obtained from the quarterly MDS dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and was totally dependent on two staff for toileting and transfers. The MDS further identified R31 was always incontinent of bladder and bowel and was not on a toileting program.	F 690	tasks for certified staff. DON or designee will complete turning and repositioning/toileting audits weekly x 4, then monthly x 3. DON or designee will monitor weekly for compliance. DON or designee will complete B&B audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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R31's care plan dated 11/2/18, identified incontinence of bladder and bowel related to hemiplegia, dementia and decreased mobility. The care plan directed staff to assist R31 to lay down via a mechanical lift to check and change incontinent product upon rising, after meals, before bed and as needed.

On 11/7/18, R31 was continuously observed from 6:25 a.m. unit 11:34 a.m. (5 hours and 9 minutes). At 7:50 a.m. nursing assistant (NA)-F approached R31 from the back, tilted the wheelchair back and left R31 in the television lounge. At 8:41 a.m. the registered dietician (RD) wheeled R31 in his wheelchair to the dining room table. R31 remained in the dining room until 10:00 a.m. when staff wheeled him to the main dining room for an activity. R31 remained in the activity until 11:20 a.m. when surveyor intervened. At 11:20 a.m. NA-F stated when he came to the unit at 7:50 a.m., he had noticed R31 in the television lounge and had tilted the wheelchair back and at the same time he uncrossed R31's legs. NA-F confirmed he had not checked and changed R31 after breakfast. At 11:40 a.m. NA-F brought R31 into the room, and with assistance from NA-I, used a mechanical lift to get R31 onto the bed. R31's brief was saturated with urine.

R81's diagnoses included dementia with Lewy bodies, Alzheimer's disease, muscle weakness and neuromuscular dysfunction of bladder, obtained from the quarterly MDS dated 8/30/18. In addition the MDS indicated R31 had severely

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impaired cognition and required physical assistance of two staff with toileting, bed mobility and transfers. The MDS further indicated R31 did not refuse cares and was frequently incontinent of bladder and bowel.

R81's care plan dated 9/12/18, identified R81 was incontinent of bladder and bowel related to immobility, obesity, congestive heart failure and dementia. The care plan directed staff check brief on rising, after meals, at bedtime hours and as needed.

On 11/7/18, R81 was continuously observed from 6:25 a.m. to 9:54 a.m. (3 hours and 15 minutes). During the observation no staff went to R81's room until at 9:40 a.m. when surveyor approached licensed practical nurse (LPN)-E and indicated R81 had not been checked and changed since 6:25 a.m.

At 9:44 a.m. nursing assistant (NA)-F stated he did not know the last time R81 had been checked and changed as he had come in late that morning. At 9:52 a.m. NA-F approached R81 and cued her they were going to check, change and reposition her and R81 stated "yes." At 9:54 a.m. which was 3 hours and 29 minutes of continuous observation NA-F and NA-M turned R81 to the left side. R81's incontinent pad was saturated with urine and her skin was visibly wet.

At 10:05 a.m. LPN-E stated she would have expected the NA's to turn, reposition and toilet R81 according to the care plan and if they were not able to get it completed timely they were

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F 690	Continued From page 55 supposed to let her know. At 10:30 a.m. NA-F stated he did not know he was assigned to R81 until surveyor asked about it. On 11/7/18, at 2:02 p.m. RN-I reviewed the actual working schedule and verified R81 was assigned to NA-F's team from the beginning of the shift. RN-I stated there was no reason NA-F was confused if he was assigned to assist R81. On 11/7/18, at 2:02 p.m. registered nurse (RN)-I stated residents were supposed to be toileted as directed by the care plan. On 11/7/18, at 2:26 p.m. the director of nursing (DON) stated all resident's who required to be checked and changed were supposed to be provided cares as directed by the care plan.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		12/18/18

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F 725	Continued From page 56 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement assistance with meals, and provide timely assistance with personal cares according to the residents' assessed need and as directed by the care plan. This practice had the potential to affect all residents who resided in the facility. Findings include: Refer to F677: The facility failed to ensure adequate grooming was provided to 1 of 5 residents (R31) who was dependent on staff for activities of daily living (ADL's). Refer to F684: The facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) for 1 of 1 resident (R108) reviewed for limitations in range of motion.	F 725	F725: Sufficient Nursing Staff R31 was assisted with grooming and R108 was assisted with ROM during ADLs. R31 and R81 has been turned and repositioned per facility policy. Current residents have the potential to be affected by this alleged deficiency. R224 care plans involving urinary continence/incontinence and B&B assessments have been reviewed and updated. Current staff were re-educated regarding facility expectations for meeting residents needs, range of motion, the facility□s policy on repositioning and the use of the 3 day voiding diary upon admission. IDT was re-educated on the completion of the bladder assessment and resulting tasks	

F 725 Continued From page 57

Refer to F686: The facility failed to ensure 2 of 5 residents (R81, R31) identified at risk for pressure ulcers received timely repositioning. The failure of the facility to consistently implement a turning and positioning program resulted in actual harm, when R81 acquired three (3) new stage II pressure ulcers (partial-thickness loss of skin with exposed dermis).

Refer to F690: The facility failed to provide timely toileting for 2 of 7 residents (R31, R81) reviewed for bowel and bladder. In addition, failed to ensure 1 of 7 residents (R224) received services and assistance to maintain bladder continence.

Resident interviews:

R9 was interviewed on 11/05/18, at 9:11 a.m. When asked about staffing R9 stated there was not enough aides. "It takes a long time to get help. Not too long ago, a couple of months ago, on the night shift at 3:00 a.m. I had a bowel movement and I got changed at 8:00 a.m. The aide said the call light had not come on. I put the call light on every 15 minutes, they come in turn off the light. Waiting beyond 30 minutes is too much time to wait to get help. I think they need a float person. When I first got here I was dizzy and needed more help. I still need assistance to go to the bathroom."

R219 was interviewed on 11/5/18, at 09:58 a.m. and indicated that "they are short on aides." They used to have 5-6 aides on the floor. One night there was one aide on the floor until someone could come in. Aides are working double shifts. Lots of aides have quit. They can't get me

F 725

for certified staff.

DON or designee will complete observation audits for grooming, range of motion, turning and repositioning, and B&B weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance.

Staffing patterns are determined by resident assessments and individual plan of care, as well as the consideration of the current census, acuity, and diagnoses of residents residing in the facility, in accordance with the facility assessment. Staffing fluctuations and adjustments will be completed by the administrator, DON, and scheduler each day as needed to provide competent and skilled staff in the facility.

Current nursing staff have been re-educated regarding facility expectations for meeting resident needs. Current staff has been re-educated to notify the unit manager or supervisor for any needs that require licensed nursing.

An audit of call light response times were performed for the following residents: R9, R219, R11, R184, R227, R149, R242, R697, R202, R151, R173, R170, R215, R40, R61, and R93 to ensure that each unit had the necessary call light equipment for all licensed beds. Identified concerns regarding working equipment were forwarded to maintenance and fixed

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F 725	Continued From page 58 repositioned as frequently as I need. They take care of 12 people by themselves. They put new nurses on this floor and 4 nurses have quit since I was here. People from Florida bought this place and they do not care about us. I have had people who left in the middle of cares because they have said they have to go, their shift was done. I have complained to the nursing supervisor and she is now gone. My light will be on for 2 hours before they come in to turn me or bring me water. Staffing is a big problem. " R11 and family member were interviewed 11/4/18 at 2:00 p.m. and stated the call lights are not answered timely, especially at night there are only 2 aides and would wait up to 2 hours for help and at times staff come into the room turned the call light off and stated they would be back but never did. During a follow up interview with R11 on 11/5/18 at 9:00 a.m., R11 stated she had been waiting since 5:00 a.m. to have a bath. R11 stated on several occasions she had brought complaints to registered nurse (RN)-A), who was the nurse manager, about staffing complaints and long call lights but it had not improved. R11 further stated the staffing levels were decreased to three aides on the unit about 3 months ago. R184 was interviewed on 11/4/18 at 6:30 p.m. and stated there were concerns about waiting up to 4 hours to have a call light answered. R184 stated he had waited 4 hours last Friday after being incontinent of stool, and had complained to the nurse manager. On 11/4/18, at 12:57 p.m. R451 stated the facility was very short staffed. R451 stated he had	F 725	immediately. DON or designee will complete call light observation audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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F 725	Continued From page 59 to wait two hours while sitting in stool, to get his incontinence product changed. On 11/4/18, at 1:01 p.m. R227 stated her medications would be two hours late at times, and when she asked why, she was told staff were busy. On 11/4/18, at 1:30 p.m. R149 stated staffing was bad. R149 stated "I have had to wait two hours when I needed to be changed because I had a bowel movement in my brief." On 11/4/18, at 2:35 p.m. R242 stated "I do not want to wait 30 minutes for assistance to walk to bathroom. They placed my walker across the room, so I would not go to the bathroom without help. I was not incontinent prior to admission." On 11/4/18, at 3:07 p.m. R697 was lying in bed with oxygen on by a tracheostomy (an artificial opening in the neck to allow a patient to breath). There was a suction machine next to the window. R697 stated it was difficult to speak and requested to write her answers. R697 wrote,"They take too long to answer my call light. I have waited up to two and a half hours for someone to respond to my button [pointed at the call light]. This just doesn't happen once, it happens all the time." R697 wrote, "I could die if I wait too long. It scares me." On 11/4/18, at 4:13 p.m. R202 stated when he put the call light on it would take the staff 45 minutes to come and put him on or off the commode. R202 stated he could do it himself but the staff wanted him to wait for assistance	F 725		

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because he recently had his lower leg amputated.

On 11/4/18, at 4:20 p.m. when asked if he was getting the care and assistance he required, R151 stated "they are short of help here. They have cut the hours of the staff here and tell them to either leave an hour early or come late. So no one wants to stay and work here. You wait for an aide for one to two hours sometimes. Like I was supposed to be up at 4 p.m. and look am still in bed and no one has come to even let me know what is going on. Some nights it's only one aide and people here have to wait for that one person and they never come."

On 11/4/18, at 4:30 p.m. R173 stated the staff have too many patients, they are so busy. R173 stated "I have had to wait 30 to 45 minutes for my call light to be answered. I have been in pain and want a pain pill."

On 11/4/18, at 4:38 p.m. R170 stated "Sometimes I have to hold to go poop because there is no help anywhere. There are a lot of people but they walk around. I need to use the toilet with their help. That's the only thing I got to b**** about. They just need to train people on how to take care of people."

Staff Interviews:

On 11/4/18 at 2:15 p.m. nursing assistant (NA-A) stated the aides on the unit are assigned 13 residents, said there was not enough staff and thought the unit required 4 aides to meet the

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needs of the residents in the unit. At 2:40 p.m. when asked to assist R11, NA-A stated 2 aides were needed to use the lift which R11 used for transfers and she was the only aide on the unit yet for the afternoon shift.

On 11/4/18, at 6:50 p.m. licensed practical nurse (LPN)-F stated she worked on a different floor and had been floated to the floor. When asked about staffing LPN-F stated it was hard to get the work done at times because she had to help the NA's. When asked how she was able to identify the resident correctly when administering medication LPN-F stated she depended on the NA's to point out the residents.

On 11/4/18, at 4:18 p.m. registered nurse (RN)-L stated the 700 nurse did not come in so they were splitting the entire 700 hall between three nurses. RN-L stated there was one nursing assistant (NA) on the 500 hall and one on the 600 hall and a NA that floated between the two halls.

On 11/6/18, at 8:03 a.m. NA-C was interviewed after morning cares were done for R78. NA-C showed srveyor the work sheet and counted out loud he had 13 residents he was responsible for cares. NA-C stated he worked at his own pace and at times he had to wait for another NA to come in and assist him when he used the lift to transfer residents. When asked if he thought the unit 2SW had enough staff he just "laughed" and would not comment.

On 11/7/18, at 6:29 a.m. NA-L stated "you can just tell we are short." When you get home you

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are so tired because you will be running the whole day from room to room." NA-L stated management was aware and nothing had been done and yet the resident's in the unit needed more assistance and required two staff for cares and transfers.

On 11/7/18, at 1:30 p.m. anonymous staff indicated "It is about profit here. They don't care about the resident care. We seriously need the help here to provide the residents with quality care. They know but it's not a priority for management and the cooperation. Sometimes the residents are so helpless that you just don't know what to do or where to begin. You can attempt to fix the problems but they continue to come and just not enough help around here period."

On 11/8/18, at 10:26 a.m. LPN-G stated "they staff according to the census and sometimes we work okay and sometimes we work short. It can be difficult when we work short to get the work done because you have to help the nursing assistants and the residents." LPN-G stated at times resident would have to wait for a while to get the assistance because there was just nobody to help especially when a resident required two staff assistance with cares.

Resident observation:
On 11/6/18, at 6:58 a.m. R215 was overheard calling out "Hello change my diaper." LPN-D was observed down the hallway and was overheard state to nursing assistant (NA)-L "he needs help. When LPN-D returned to the nursing station where the medication cart was parked surveyor

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indicated R215 was calling out and LPN-D stated "I have told the aide."
-At 7:01 a.m. R215 continued calling out at this time registered nurse (RN)-K went into the room and R215 stated "change my diaper." RN-K then stated to R215 "someone is coming" as she left the came out of the room at the nursing station LPN-D stated "I have told [NA-L]."
-At 7:06 a.m. to 7:11 a.m. R215 started calling out "help me change my diaper" at this time RN-N and LPN-D were both standing at the medication carts which were located outside the nursing station across from R215's room.
-At 7:12 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room.
-At 7:45 a.m. to 7:48 a.m. RN-N went into R215's room to give R215 medications and as she left R215 stated to her "Hi don't run away." RN-N turned around and approached R215 and R215 was overheard state in a loud voice strained voice "change my diaper." RN-N stated "change what" but R215 then stated "never mind" as RN-N left the room.
-At 7:49 a.m. surveyor told RN-N R215 was asking staff to change his incontinent pad. RN-N stated she did not understand what R215 wanted as he was heard to understand. RN-N stated she was going to find help.
-At 7:50 a.m. surveyor intervened and asked LPN-D when R215 was going to be assisted as it had been 50 minutes since R215's had asked. LPN-D stated she was going to find help.
-At 7:53 a.m. as RN-K and RN-N approached R215 he stated "what took so long."
-At 7:58 a.m. as NA-E and NA-L approached R215 yelled out "change my f****** diaper."
-At 7:59 a.m. NA-E was observed wipe stool off

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F 725	Continued From page 64 R215's bottom and stated R215's pad was dry. On 11/6/18, at 8:07 a.m. RN-K stated "if help is needed it's provided." RN-K stated "when someone has to go he has to go." Resident Council: Review of the Resident council minutes for the past 3 months revealed on September 17, 2018 the council notified the new director of nursing of nursing concerns, and they would be filed on a concerns form. The concern form was dated 10/8/18, indicated call lights were not being answered in a timely manner. The response from nursing was that nursing staff would be re-educated on using the call light pagers and on expectations. During the resident council meeting held on 11/6/18 from 10:30 to 11:30 a.m. and was attended by seven residents and the ombudsman. R11 stated the council had submitted three grievances because they had been discussed in the council for several meetings and not resolved. The call light time response by nursing staff was the main grievance and it had been an ongoing issue. R40 stated the staff come in and ask what was needed, then turn off the light and said they will return "but they don't come back." R40 reported waiting two hours, and hearing others on the unit calling out for help. R61 stated they would have to turn the light on three times before getting help and this was common practice. R93 reported having the call light taken from residents when it was used	F 725		

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to call for assistance. R93 stated he and other residents had waited a long time again the previous night on the night shift. R93 further reported wound treatments were not always completed as ordered. In additon, R61, R40, and R93 reported passing bedtime snacks was not always done because there were not enough aides on duty.

During the resident council meeting the members in attendance expressed a concern that comments they were bring up in the council meetings about staffing issues did not get written into the minutes, and a response was not given to the council on efforts to solve the problem.

System:
Call light audits for the second floor north unit were reviewed for the month of October 2018, the audit was for 14 residents and included 47 episodes of the call lights being on for 60 minutes or more. The assistant adminstrator was interviewed on 11/7/18 at 1:06 p.m., and stated they had audited a few residents on 2 north for the past 3 months. She stated she did not investigate call light times greater than an hour for resident issues but did see which aide was assigned. She stated the audit was not able to track instances when an aide would turn off the light and return later to meet the resident's need. She stated she was aware of the resident council concerns about staffing and had talked to them but offered no written response. She stated the new policy to have aides carry a pager with them to indicate a call light was on started in September 2018.

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F 725 — Continued From page 66 — F 725

Interview with the staffing coordinator on 11/7/18 at 2:33 p.m. if staff call in will attempt to fill the need and if not will make administration aware.

The policy for the nursing staff to carry pagers was identified in a memo dated 9/7/18 which indicated all staff were to sign out and carry a pager to be aware of the call lights. The current call light system had a banner on the unit which ran the room numbers of call lights activated and the pager would also sound to alert staff.
The sign out sheets for the second floor for 11/2/18, 11/3/18, 11/5/18, and 11/6 18 had none of the pagers signed out for the evening and night shift, and 3 signed out on the day shift. The RN-A verified that the day and evening shifts would have 6 staff on them.

On 11/8/18, at 2:36 p.m. during an interview with the administrator, the director of nursing and the intern administrator, the administrator stated the facility was being staffed by acuity and transfers. When asked about the observations of staff not repositioning residents, not toileting residents timely and providing the services and care needs both stated some of the staff who were involved in the situations had been let go as this was not acceptable standards.

The facility assessment dated 7/23/18 indicated the needs of residents, past survey performance, and determined they had sufficient staffing.

F 757 SS=D — Drug Regimen is Free from Unnecessary Drugs — F 757 — 12/18/18
CFR(s): 483.45(d)(1)-(6)

§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from

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F 757	Continued From page 67 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess and monitor bruising for 1 of 1 resident (R56) reviewed who was receiving an anticoagulant (blood thinner). Findings include: R215's diagnoses included heart failure, dementia and atrial fibrillation obtained from the quarterly Minimum Data Set (MDS) dated 10/12/18. In addition, the MDS indicated R215 had severely impaired cognition and used an anticoagulant 7 out 7 days during the assessment period.	F 757	F757 R215 has been assessed and monitored for bruising. Current residents receiving an anticoagulant have the potential to be affected by this alleged deficiency. Orders and care plans have been reviewed for current residents on anticoagulation therapy. Care plans have been updated for current residents on anticoagulation therapy.	

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R215's care plan dated 7/31/18, identified a risk for pressure ulcer related to decreased mobility, incontinence, cognitive loss and diabetes. The care plan directed staff to assess/record/monitor pressure wound healing, however the care plan did not identify use of an anticoagulant or monitoring of side effects.

R215's Physician orders dated 7/7/18, and 11/2/18, revealed R215 was receiving Prednisone 5 mg one time daily for polymyalgia rheumatica, Coumadin 2 milligram (mg) (Sunday, Monday, Wednesday, Thursday and Saturday) and Coumadin 1.5 mg (Tuesday and Friday) for atrial fibrillation. A review of the medication administration record (MAR's) and treatment administration records (TAR's) for October and November 2018 lacked evidence of monitoring of the adverse reactions/effects of the two medications, even though R215 received the medications daily.

On 11/4/18 12:56 p.m. R215 was observed lying in bed. R215 raised his hands and revealed purple bruises varying from dark to light on the right hand, right elbow and in the left inner elbow. When asked how he got the bruises R215 stated he did not know, after looking at his hands.

On 11/4/18, at 7:09 p.m. family member (FM)-D was observed in R215's room assisting with supper. When approached and asked about the bruises FM-D stated he had also noticed them and thought R215 did bruise easy.

On 11/5/18, at 9:30 a.m. and on 11/6/18, at 8:00

Provider's Plan of Correction (F 757):

Current licensed and certified nursing staff were re-educated on monitoring residents on coagulation therapy for bruising.

CRC or designee will complete anticoagulation audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance.

Results of the audits will be forward to the QAPI committee for continued quality improvement and compliance x 3 months.

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a.m. R215's brusing remained with no documentation in the medical record.

During further review of the medical record it was revealed the consultant pharmacist had reviewed R215's medical chart on 10/5/18, and indicated in progress note, "No Recommendations".

On 11/6/18, following surveyor inquiry, a Progress Note dated 11/6/18, indicated "Discolored bruises noted on Resident's both hands this shift. When asked states "I don't know." Staff assessed,dark discolored bruises noted and which measured 2.7 cm [centimeter] x 2.3 cm Right hand, 2.8 cm x 2.8 cm Right elbow and 0.3 x 1.1 cm Left inner elbow. In addition, following inquiry, an anti-coagulant care plan was developed along with a nursing order to monitoring for bruising and bleeding due to anticoagulant therapy.

On 11/6/18, at 2:17 p.m. registered nurse (RN)-K stated all residents who were on a blood thinner were supposed to have a care plan to identify they bruised easy "It was an oversight." In addition RN-K and RN-I verified there was no documentation of the bruises in the medical record including the weekly skin assessments. Both RN's also verified there was no monitoring in place for staff to monitor and observe R215 for bruising and bleeding due to anticoagulant/blood thinners. RN-I stated all staff were supposed to observe for skin changes and were to report any concerns to the nurses so they could assess and investigate the cause.

On 11/7/18, at 2:26 p.m. the director of nursing

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F 757	Continued From page 70 staff was supposed to report the bruises to the nurse and then the nurse was to complete an incident report for the bruises and monitoring was to be initiated.	F 757		
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. §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 store refrigerated medications between 36 - 46 degrees Fahrenheit	F 761	F761 Expired stock medications have been	12/18/18

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(F) in 1 of 5 medication refrigerators. Additionally, the facility failed to remove expired stock medications from medication storage on 4 of 9 medication carts, which had the potential to affect residents residing on the transitional care unit (TCU), first floor south, third floor north and second floor north west.

Findings include:

On 11/8/18 at 9:00 a.m., registered nurse (RN)-E verified the first south west medication refrigerator temperature log indicated the temperature was not kept within the allowable range (36 - 46 degrees F). Review of the log indicated the refrigerator temperature was less than 36 degrees F., 25 times in the last 26 days. Stored in the refrigerator were 17 vials of Lantus insulin for R89, and 2 Levemir flex pens and 11 Novolog flex pens for R51, and 11 vials of influenza vaccine. RN-E indicated maintenance would be called to adjust the temperatures

During medication storage review of the TCU 600 wing medication cart on 11/5/18, at 10:32 a.m. with licensed practical nurse (LPN)-A, the following medications were found to be expired:
-Folic Acid 400 mcg 110 tablet bottle, one fourth full, expired 7/18.
-Vitamin D3 50,000 iu, 24 caplet bottle, 9 tabs in the bottle, expired 9/18. LPN-C indicated these medications were stock.

During mediation storage review of the TCU 500 wing medication cart on 11/5/18 at 10:55 a.m. with registered nurse (RN) - D, the following

F 761

removed from the medication carts.

Current licensed nursing staff were re-educated on removing expired medications from the medication carts.

DON or designee will complete expired medication audits weekly x 4, then, monthly x 3. DON or designee will monitor weekly for compliance.

Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.

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medications were found to be expired:
-Vitamin E 400 iu 100 softgel, 3/4 full expired 8/18.
-Optic-vits with lutein 36 tabs bottle, 1/2 full expired 6/18.
-Fexofenadine hcl tablet 180 mg, 30 tab bottle 1/2 full, expired 10/18.
-Magnesium oxide 500 mg, 100 tablet bottle, 3/4 full expired 10/18.
-Aspirin 325 mg, 100 tablet bottle, 3/4 full, expired 1/18.
-Calcium 600 mg +400 iu vitamin D, 60 tablet bottle, 3/4 full, expired 10/18.
All medications were verified by RN-D, as being stock medications.

During medication storage review of 3 north near medication cart on 11/8/18 at 8:44 a.m., with LPN-B, the following medications were found to be expired:
-Calcium 600 mg, 150 tablet bottle, full bottle, expired 10/18
-Magnesium oxide 500 mg, 100 tablet bottle, 3/4 full expired 6/18
-Zinc sulfate 220 mg, 100 tablet bottle, 1/2 full, expired 9/18
-Vitamin D 400 iu, 100 softgel bottle, full bottle, expired 8/18
-Vitamin D3-2000 iu, 100 softgel bottle 1/4 full, expired 5/18
-Naproxen 220 mg 100 tablet bottle, 1/4 full, expired 6/18
All medications were verified by LPN-B as being stock medications.

During medication storage review of 2 west far north medication cart on 11/8/18, at 9:14 a.m.

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F 761	Continued From page 73 with LPN-C, the following medications were found to be expired: -Magnesium oxide 500 mg, 100 tablets, 1/2 full, expired 10/18. All medications were verified by LPN-C as being stock medications. Review of facility's discarding and destroying medication policy dated 2012: 12. Expired medications will be disposed of per state or contract pharmacy guidelines. Review of the facility's storage of medication policy dated 2007 indicated: 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses; station or other secured location. Medication must be stored separately from food and must be labeled according.	F 761		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents received the prescribed diets as ordered for 4 of 5 (R109, R115, R168, R83) residents reviewed	F 808	F808 R109, R115, R168, R83 have been provided with prescribed diets as ordered.	12/18/18

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F 808	Continued From page 74 during dining. Findings include: On 11/7/18, at 10:55 a.m., R109 indicated she was to receive a gluten free diet, and it was not being offered. She showed the menu for 11/4/18, which included cream of wheat, and whole wheat toast for breakfast. R109 indicated that she would ask for oatmeal, and was told the facility was out of oatmeal. R109 indicated no dietician had talked to her. During interview on 11/8/18, at 9:30 a.m., Registered Dietician (RD)-A indicated nursing staff communicated with the dietary staff when residents had issues. RD-A indicated no staff had informed her that R109 was having issues or concerns. On 11/8/18, at 10:20 a.m. RD-A indicated she had met with R109 and "they were going to work on some things." Review of R109's medical record indicated R109 was admitted on 6/7/18, with diagnosis including, tibia fracture, multiple sclerosis, depressive disorder, gastro-esophageal reflux disease and muscle weakness. Review of R109's physician orders dated 11/8/18, included an order for gluten restricted diet with a start date of 6/12/18. Review of R109's plan of care initiated on 6/13/18, indicated "provide, serve diet as ordered (Gluten restricted, Regular Texture, thin Liquids)", resident prefers to eat meals in room, honor food preferences as able, and RD to evaluate and make diet changes recommendations as	F 808	Current residents with therapeutic diets have the potential to be affected by this alleged deficiency. Dietary Manager and Licensed Dietitians were re-educated on the Diet Orders & Other Resident Information policy and procedure and Resident Food Preferences policy and procedure. Current dietary staff were re-educated on the process for offering residents preferences. Dietary manager or designee will audit 60 resident trays weekly x4, then, monthly x 3. Dietary manager or designee will monitor for compliance weekly. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance for 3 months.	

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F 808	Continued From page 75 needed." Review of Progress Notes dated 11/8/18, indicated the following : Nutrition Note - R109 complained of food, visited with resdient on regular diet with gluten free foods. R109 reported she prefers to be gluten free and dairy free per choice for health reasons. Gluten free bread available for toast and sandwiches as well as gluten free muffins available for resident. Resident reports enjoying fresh fruit and vegetables. Multiple food dislikes. Select menu in place. Reviewed always available foods for resident to request in place of main entrees when selecting meals which resident acknowledged. Kitchen Staff notified who also report have visited with resident for food preferences. Resident seems to be very particular with foods, states usual home breakfast may include avocados and sardines; items not available in community. Resident declined wanting gluten free cold cereal, does consume oatmeal and eggs though states not usual items she would eat at home. Continue to encourage resident to request additional items as able to honor food preference for resident to be gluten free. Nursing and food service staff notified. Interview with R109 on 11/08/18, 10:52 a.m. she indicated she did not think anything was going to change, but would give the facility a chance. R115's quarterly minimum data set (MDS) dated 9/4/18, indicated he was moderately cognitively impaired and required supervision while eating after meal set up. R115's care plan dated 10/2/18, indicated a potential nutrition/hydration	F 808		

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problem related to a mechanically altered diet, coughing with meals and weight loss. R115's Order Summary Report identified a physican's order dated 9/19/18, for a mechanical soft, ground texture diet with nectar thick liquids.

During observation on 11/4/18, at 5:24 p.m. R115 was in the dining room during the evening meal. R115, along with all other residents on a mechanical soft diet were served pureed food.

At 5:56 p.m. R115 received a meal of pureed food even though his diet slip identified a mechanical soft diet. R115 did not eat his meal. R115 was upset with the meal choices and was not eating his food. He was served an alternate meal of pureed quiche and spinach which he also refused to eat. At 6:56 p.m. R115 was asking for a peanut butter sandwich and asked, "how long does it take to make a sandwich?" At 6:57 p.m. R115 told a staff member, "I asked for a sandwich around quarter to six, I still don't have it."

On 11/6/18, at 8:35 a.m. R115 received a meal that included pureed bread. R115 put pepper on the bread which presented as a white gelatinous blob. R115 did not eat the pureed bread.

At 12:06 p.m. R115 received a chopped up pot pie and mashed potatoes and gravy along with a bowl that contained a brown mixture. R115 ate all of the food on his plate.

During observation on 11/7/18, at 8:44 a.m. R115 was served eggs with cheese and regular toast. In addition, R115 was served thin liquids of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING ______ B. WING ______	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 808	Continued From page 77	F 808		

milk and juice. R115 had eaten all of the toast and drank some of the milk and all of the juice, and was observed coughing at the table.

R168's annual Minimum Data Set dated 10/1/18, indicated he was moderately cognitively impaired and required supervision during meals. R168's Order Summary Report identified a physican's order dated 2/14/28, for a mechanical soft, ground texture diet with an ok for regular bread. A Nutritional Assessment dated 10/1/18, indicated R168's meal intakes varied from 51 - 100% and indicated a diagnosis of dysphagia.

During observation on 11/4/18, at 5:24 p.m. R168 was in the dining room during the evening meal. R168 was served pureed food.

On 11/6/18, at 8:24 a.m. R168 was in the dining room and was served scrambled eggs and pureed toast, even though his diet slip indicated he could have regular bread. R168 left the pureed bread on the plate and did not eat it.

At 12:03 p.m. during the noon meal R168 received a plate with a corn dog, tater tots and salad. A NA removed his salad from the table then returned and removed the whole tray. At 12:07 he received a new tray with chopped up pot pie and mashed potatoes and gravy and a whole piece of pie.

R83's quarterly MDS dated 6/31/18, indicated he was severely cognitively impaired and required supervision and physical assistance to eat. R83's Order Summary Report identified a physican's order dated 12/13/17, for a mechanical soft,

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	245183	A. BUILDING ______ B. WING ______	C 11/08/2018

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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F 808	Continued From page 78	F 808		

chopped texture diet. The order indicated R83 may request regular texture meals and directed staff to cut meat into small pieces. R83's care plan dated 9/1/18, identified a dysphagia (difficulty in swallowing) diagnosis and a diet of mechanical soft food.

During observations on 11/6/18, at 12:29 p.m. R83 was seated at a table in the dining room awaiting his noon meal. At 12:30 p.m. R83 requested a corn dog. DA-B served a corn dog, chopped up as directed by R83's diet. Nursing assistant (NA)-C returned the plate to to DA-B and stated R83 would not eat the chopped up food and requested two whole corn dogs. She stated R83 would "get mad" if she served the chopped food. NA-C served the whole corn dogs to R83 and left the table.

During interview at 12:37 p.m. DA-B stated she gave R83 the right meal but NA-C told her to give him whole corn dogs so she did what NA-B asked.

At 12:38 p.m. NA-C stated R83 would not take the chopped up food, even though she had not offered it to him. She stated if she would have offered it, "it would have been a problem." She stated she thought the dietician knew about it.

At 12:40 p.m. registered nurse (RN)-K stated the NA's were "absolutely" not allowed to upgrade a residents diet. She stated staff should be following the diet slip.

During interview on 11/6/18, at 12:45 p.m. registered dietician (RD)-A stated nursing

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F 808	Continued From page 79 assistants were not allowed to upgrade a residents diet. RD-A reviewed R83's care plan and stated staff were to monitor for difficulty with chewing and swallowing. RD-A stated the care plan did not contain any modifications to R83's diet and did not contain any risks and benefits related to not following his prescribed diet. When asked about the differences in the chopped and ground diets, RD-A stated if a resident was on a ground diet they could only have pureed bread. At 8:50 a.m. RN-I stated all staff in the dining room should be aware of the residents diet and were responsible to ensure the correct food was served. During interview on 11/4/18, at 5:33 p.m. Dietary aide (DA)-A stated she was not sure what the residents on a mechanical soft diet could eat so she served them all pureed food. During interview on 11/7/18, at 9:09 a.m. DA-B stated the aides tell her what they want her to serve and stated, "that's what I give." When asked about the toast for a mechanical ground diet, DA-B stated, "pureed, I think. It's written here somewhere. Maybe you should ask the dietician." During interview on 11/8/18, at 10:28 a.m. the director of dietary services (DDS) stated she had heard about the diet concerns on the third floor. The DDS stated staff received training related to food safety and diet and should know what food to serve. She stated the dietary aide should not give food that was not on the diet order. The DDS stated she rounded in the dining rooms during	F 808		

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F 808	Continued From page 80 meal service but did not conduct any formal audits to ensure meals were provided as directed by the physicians order. The DDS stated on 11/4/18, during the evening meal all of the resident on a mechanical diet were served pureed food. She stated the cook had not made any mechanical soft food and stated by the time she realized it, it was too late to make more food. On 11/8/18, at 1:36 p.m. the director of nursing (DON) stated she had heard staff were giving incorrect diets. The DON stated nursing and dietary staff were responsible for ensuring the correct diet was served. A facility policy titled Therapeutic Diets dated March 2016, indicated residents on therapeutic diets will not receive extra or reduced portions that are not part of the diet unless approved by the physician in conjunction with the registered dietician.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		12/18/18

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F 812	Continued From page 81 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed ensure food stored in refrigerators was properly dated and labeled in 4 of 6 refrigerators and failed to ensure 5 of 6 refrigerators, 1 of 1 freezer, 1 of 2 microwaves, 2 of 2 stainless steel storage cabinets, and 1 of 2 cereal carts were clean. Findings include: On 11/04/18, at 11:48 a.m. the initial tour of the kitchen and kitchenette was conducted with the executive chef (EC). The walk in freezer did not have a thermometer on the inside. The EC obtained one and placed it in the freezer. On the floor of the walk in freezer were pieces of paper debris. In the walk in cooler there was an open bag of hard boiled eggs that was not marked with the date open. There was also a meat sandwich wrapped in plastic wrap that was not marked with the date prepared. The floor of the walk in cooler had debris and smears of dark gray substance on the floor. The EC was asked how often the floors were swept and mopped. The EC was unsure, but another kitchen staff member stated the staff tried to sweep and mop it twice a week. At 11:59 a.m. a second walk in freezer was	F 812	F812 Food stored in refrigerators has been properly dated and labeled. Refrigerators, freezer, microwaves, stainless steel storage cabinets, and cereal carts have been cleaned. Current dietary staff were re-educated on the Food Supply and Storage policy and procedure and the Food Handling Guidelines policy and procedure. Dietary manager or designee will audit 15 times weekly x 4, then, monthly x 3. Dietary manager or designee will monitor for compliance weekly. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance for 3 months.	

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F 812	Continued From page 82	F 812		

inspected and the floor of that freezer was dirty. In the kitchen there were two metal storage cabinets for kitchen equipment, bowls, and utensils. Both cabinets had debris on all of the shelves and smears of grease and/or a white substance on the outside of the doors.

Following the main kitchen the 2 west kitchenette was inspected with the EC. A stack of pre-sliced cheese was loosely wrapped in plastic wrap. The plastic wrap was not sealed and the cheese was exposed to the air. The cheese was not marked with the date it was placed in the refrigerator. An undated Magic Cup Nutritional Supplement was in the refrigerator. The label indicated the Magic Cup could only be kept for 3 days after thawing. There was no date on the container indicating when it was removed from the freezer and placed in the refrigerator. The bottom of the refrigerator was covered with a red juice spill. A cart holding the dry cereal dispensers was covered with pieces of cereal around the dispenser on the top shelf. On the second shelf there was debris and dust.

At 12:36 p.m. the kitchenette on 3 west was inspected. There was an open bag of Sysco Raisins that were not dated when opened. The interior bottom of the refrigerator was full of juice spills.

At 12:45 p.m. the Bridgeway front kitchenette was inspected. A carton of med pass 2.0 nectar thick supplement drink was open and undated. The microwave had a used paper towel on the turn table and food splatters on the door.

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F 812	Continued From page 83 At 4:54 p.m. with cook (C)-A the Bridgeway back kitchenette refrigerator was inspected. On the third shelf in the back was a dish of fruit that was not dated. C-A put the dish in the dirty dish rack. The inside of the refrigerator was also dirty with juice spills. C-A stated housekeeping was responsible for cleaning the refrigerators. On 11/06/18, at 10:08 a.m. a second tour of the kitchen and kitchenettes was conducted with the dietary director (DD). In the main kitchen walk in freezer there were five tator tots on the floor and on the plastic flap hanging in the door of the freezer there was an orange brown substance smeared on the plastic. The DD stated the food needed to be cleaned off the plastic and the floor of the freezer and walking coolers should be swept and washed daily. The floor of the walk-in cooler was still dirty and had paper scraps on it. The two metal cabinets still had smears on the front and had debris on the shelves. The DD stated all food going into the refrigerator or freezer needs to be covered appropriately and marked with the date open or expiration date. The DD added the staff were responsible for making sure the food was labeled and dated appropriately. The kitchenettes were inspected after the kitchen. The 2 west kitchenette refrigerator still had juice spills on the inside bottom and the cart with the dry cereal dispensers was still covered with cereal crumbs, dust and debris. The 3 west kitchenette refrigerator was still dirty with juice spills on the inside. The refrigerators on Bridgeway Front and Back still contained juice spills. On 11/7/18, at 2:23 p.m. the DD stated the	F 812		

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F 812	Continued From page 84 kitchen staff were responsible for the cleaning of the refrigerators. She stated there was a schedule for that process, but the staff had not been following it. The DD stated the kitchen staff were responsible for the cleaning of the kitchen areas and refrigerators. The DD also stated the kitchen staff were responsible for making sure all open food got marked with the date it was opened or used by date. A policy for cleaning of the refrigerators was requested, but not received.	F 812		

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

F5183029

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 29, 2018. At the time of this survey, North Ridge Health and Rehab Building 01 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. North Ridge Care Center is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. In 2018 a remodel was conducted on the 800 Wing. Because the original building and the 4 additions are of existing construction, the new remodel will be surveyed as a separate building.	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/29/2018

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K 000	Continued From page 1 The facility has a capacity of 320 beds and had a census of 247 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

F5183029

Printed: 12/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **04 - 800 WING** B. WING ______	**11/29/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH** **NEW HOPE, MN 55428**

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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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	245183	A. BUILDING **04 - 800 WING** B. WING ______	**11/29/2018**

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K 000	Continued From page 1 The facility has a capacity of 320 beds and had a census of 247 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically delivered
December 27, 2018

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: State Nursing Home Licensing Orders - Project Number S5183030, H5183172, H5183173

Dear Administrator:

The above facility was surveyed on November 4, 2018 through November 8, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5183168, H5183170, H5183171, H5183172, and H5183173. H5183168, H5183170, and H5183171 were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: ______ B. WING ______	C 11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH** **NEW HOPE, MN 55428**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/4/18, through 11/8/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders,	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. During the re-certification survey on 11/4/18, through 11/8/18, complaint investigations were conducted time of the standard survey. An investigation of complaint, H5183168 was completed. The complaint was unsubstantiated. An investigation of complaint, H5183170 was completed. The complaint was unsubstantiated. An investigation of complaint, H5183171 was completed. The complaint was unsubstantiated. An investigation of complaint, H5183172 was completed. The complaint was substantiated at MN Rule 4658.1415 Subp 4 An investigation of complaint, H5183173 was	2 000		

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2 000	Continued From page 2 completed. The complaint was substantiated at MN Rule 4658.0085, MN Rule 4658.0520 Subp 2D, MN Rule 4658.0525 Subp 3, MN Rule 4658.0525 Subp 5A. B and MN Rule 4658.0510 Subp 1.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the	2 265		12/18/18

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2 265	Continued From page 3	2 265		

resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to notify a resident representative of a significant weight loss for 1 of 3 residents (R31) reviewed for nutrition.

Corrected.

Findings include:

R31's diagnoses included dysphasia, aphasia, dementia, hemiplegia, diabetes mellitus type II and anemia obtained from the quarterly Minimum Data Set (MDS) dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required total dependence on staff with eating.
R31's care plan revised 8/7/18, indicated R31 was at increased risk for nutrition related to a self "feeding" deficit, an altered diet and had a significant unplanned weight loss. The care plan directed staff to encourage family involvement and identified FM-A as the appointed health care agent due to R31's inability to communicate and make decisions for himself.
On 11/5/18, at 10:15 a.m. when asked if R31 had lost weight, family member (FM)-A stated "they don't feed him and he has lost weight. They put the water in the room but he is not assisted with it because he is not physically able to do it." FM-A also stated when he and other family members visited R31, he always ate well and

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thought when the staff told him he refused., staff just need to be patient. FM-A further stated he had noticed the weight loss over time however facility staff had not reached out to him or other family members to discuss what could be done, nor was he aware of any interventions in place for the weight loss.
On 11/6/18, from 8:18 a.m. to 8:32 a.m. R31 was seated at a table in the dining room waiting for breakfast. At 8:32 a.m. NA-D brought R31's plate of food, set it in front of R31 and left. At 8:36 a.m. NA-A came back to the table sat next to R31 and started to assist R31. At 8:43 a.m. NA-D left the table and went to the main dining room area. NA-D got two straws which she brought back for R31's beverages. At 8:53 a.m. after R31 ate a few bites of his food with sips of the juice, NA-D wheeled R31 out of the dining room and placed him by the nursing station.
At 8:54 a.m. NA-D stated R31 had eaten approximately 25% with 10 milliliters of the cranberry juice. NA-D acknowledged she had not offered R31 anything else, as he did not want to eat.
On 11/06/18, at 1:20 p.m. during a follow up interview FM-A stated he had not been notified of the significant weight loss. FM-A stated another family member had come to visit R31 during meal time and had found R31 was seated at the table with food in front of him and no staff present to assist him.
During review of medical record it was revealed R31's significant weight loss had been identified and noted in progress notes by the dietician on 7/10/18, 8/14/18, 8/27/18, 9/4/18, and 11/1/18. The dietician had also indicated 8/14/18, due to the significant weight loss in 90 and 180 days a nutritional supplement was ordered. During

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further review it was revealed on 11/1/18, the dietician had again noted R31 had a unplanned weight loss of 17.3 pounds, 10.5% in 180 days. The medical record lacked documentation of R31's responsible party being informed of the weight loss.
On 11/6/18, at 12:56 p.m. the consultant registered dietician (CRD) stated R31 was on a nutritional supplement twice daily due to unplanned significant weight loss over the last 180 days and thought R31 had leveled off in the last 90 days. When asked if anyone in the dietary department had observed R31 during meals, the CRD stated she did not think so. When asked what staff were supposed to do when a resident did not eat well, she stated staff were supposed to offer an alternate and all residents were supposed to be offered enough fluids with meals. When asked who was supposed to notify family/responsible party of R31's significant weight loss, CRD stated she would have expected nursing to have notified the responsible party as she did not know how much the family was involved in R31's care.
On 11/7/18, at 8:46 a.m. registered dietician (RD) stated since the significant weight loss had been identified R31 had been started on the nutritional supplement and thought the weight had stabilized. When asked if anyone had watched R31 during meals, RD stated "No I'm fairly new and part-time." RD stated when he completed the assessments he would ask the aide or nurse how R31 ate. When asked who notified family/responsible party, RD thought during care conferences an RD would but otherwise nursing would be doing the update.
At 9:42 a.m. the RD stated at the time the RD had written the telephone order for the nutritional

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2 265	Continued From page 6 supplement for weight loss on 8/15/18, when the nurse noted the order it was the responsibility of the nurse to have updated the family/responsible party about the weight loss. On 11/7/18, at 2:10 p.m. registered nurse (RN)-I reviewed the interdisciplinary notes and verified there was no documentation of family/responsible party being notified of the significant weight loss. RN-I stated he would have thought the RD was the one to do the notification since they were experts but also thought nursing would have done it due to the new order. On 11/7/18, at 2:26 p.m. the director of nursing stated she would have expected the dietary department to have notified the family or responsible representative of the weight loss when the supplement was initiated. The Change in a Resident's Condition or Status policy dated November 2017, directed staff "The facility staff shall promptly notify the resident, his or her attending physician and resident representative of changes in the resident's medical/mental condition and/or status..." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 265		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints	2 505		12/18/18

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2 505	Continued From page 7 Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken	2 505		

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solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest.

E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to ensure residents were free from physical restraints for 1 of 2 residents (R82) reviewed for restraint use.

Corrected.

Findings include:

R82's quarterly Minimum Data Set dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance for transfers, toileting and bed mobility. R82's care plan dated 8/4/18, identified a self care deficit and limited physical mobility. The care plan directed supervision with ambulation. The care plan further identified a risk for falls and directed staff to place R95 in a geri-chair four hours per day after lunch.

During observation on 11/4/18, from 1:30 p.m. to 4:30 p.m. R95 was lying in a reclining chair, leaning to her left side with her head resting on the armrest of the chair. R95 appeared to be asleep.

On 11/5/18, at 8:21 a.m. R95 was asleep in a reclining chair in the television room outside the nurses station on the unit. A standard wheel

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chair was observed in R95's room. R95 remained in the reclining chair until 9:26 a.m.

On 11/6/18, at 7:33 a.m. R95 was again lying in a blue reclining chair in the television room on the unit. R95 appeared to be asleep. She was leaning on her left side with her head lying on the arm rest of the chair. The chair was reclined all the way back. R95 still remained in the chair at 9:29 a.m.

During interview on 11/6/18, at 9:37 a.m. registered nurse (RN)-M stated R95 was up a lot during the night. RN-M stated R95 had been falling a lot and had gotten the reclining chair a few months ago. RN-M stated staff put her in her bed at night but if she woke up they would place her in the reclining chair. She stated R95 slept in the chair almost every night,

On 11/6/18, at 9:56 a.m. nursing assistant (NA)-C stated R95 wanted to get up by herself. NA-C stated R95 no longer walked with staff but still wanted to. NA-C stated the reclining chair kept R95 from getting up and stated if staff put her in the standard wheel chair she would try to get up and walk. NA-C stated R95 could get up from the regular chair but not the recliner, she stated "that's why we put her in it."

At 10:03 a.m. NA-K stated when R95 started getting up from the regular wheel chair, staff put her in the recliner chair. NA-K further stated the staff did not attempt other things but just put her in the chair.

During interview on 11/6/18, at 1:34 p.m. RN-K stated R95 transferred herself a lot so they

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ordered her a reclining chair. She stated R95 had not fallen in a few weeks but stated she used to fall quite a bit, especially at night, RN-K stated she thought the nurse practitioner had ordered the chair for positioning. RN-K stated she was unable to say how often staff were using the reclining chair or how they were utilizing the chair. She further stated she did not know how often R95 was up at night in the chair but stated staff should not be getting her up to sleep in the chair at night.

During interview on 11/6/18, at 2:27 p.m. licensed practical nurse (LPN)-B stated R95 was a huge fall risk. LPN-B stated the p.m. shift washed R95 up and and dressed her for bed then put her in the recliner chair to sleep because she was a high fall risk. LPN-B stated she thought R95 had an order to sit in the recliner chair after lunch but not for bed. LPN-B stated she thought the night shift put her in bed but R95 would try to get up so they put her in the reclining chair.

At 2:10 p.m. the director of nursing stated staff should be using R95's reclining chair for positioning and she should not be sleeping in the chair at night.

A facility policy titled Use of Physical Restraints dated September 2017, indicated restraints shall only be used for the safety and well-being of the resident. Restraints shall only be used to treat the residents medical symptoms and never for discipline or staff convenience or for the prevention of falls. Examples of devices that can be considered a restraint include placing a resident in a recliner that prevents them from

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2 505	Continued From page 11 rising. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure there was a system of monitoring and release of the restraint. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 505		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.	2 555		12/18/18

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2 555	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement interventions on the person centered care plan for 1 of 1 resident (R160) reviewed for behavioral concerns, and 1 of 1 resident (R11) using a full lift. Findings include: R160's admission Minimum Data Set (MDS) dated 9/30/18, indicated R160 was moderately cognitively impaired, demonstrated no mood or behavior symptoms and required extensive assistance with most activities of daily living (ADL's). Diagnoses included hemiplegia (paralysis that affects just one side of the body) and hemiparesis (weakness on half of the body) following unspecified cerebrovascular disease (stroke) affecting unspecified side, aphasia (loss of ability to understand or express speech), apraxia (inability to perform particular purposive actions), and compression of brain. The MDS indicated R160 was not receiving any scheduled or as needed (PRN) pain medications or any antipsychotic, antianxiety or antidepressant medications. Review of subsequent MDS assessments dated 10/7/18 and 10/21/18 indicated R160 exhibited no behaviors. Review of R160's plan of care, did not address any behaviors Review of R160's Progress Notes indicated the following entries: 9/20/18, 10:42 p.m. Nursing: Note indicated R160 was alert, and confused. She was pulling out the Peg and pulled out the Catheter with 10	2 555	Corrected.	

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2 555	Continued From page 13 cc balloon. The Catheter was intact and no missing part was seen. R160 was pulling out the abdominal binder, clothing, falling out of bed and refusing cares. 9/21/18, 6:03 a.m. Nursing: Note indicated R160 did not sleep through the night,was pulling out the G tube and clothing through the shift. The note further indicated R160 had a floor bed and mattress for fall prevention. 9/21/18, 2:12 p.m. Nursing Note indicated R160 had been lethargic, sleepy from around 8:00 a.m. when she was given prn Zyprexa. She was agitated , trying to pull off her G-tube and wanted to roll over the bed. Family was present and seemed to suggest "...mom needed a rest"." 9/24/18, 5:31 a. m. Nursing: Note indicated R160 was restless all nigh, rolling on the floor mat and pulling on her G-tube. G-Tube intact and placement check. Will continue to monitor. 9/24/18, 9:16 p.m.: Nursing Note indicated R160 was being monitored for readmission this shift, was resistive with cares, attempted to slap staff when giving cares. Staff unable to change tubing and assessed skin due to resistance. 10/8/18, 9:53 p.m. Nursing:Note indicated R160 was a bit agitated on shift, disconnected the feeding tube and also attempted to pull the G-tube out with her hands. 10/23/18, 6:29 a.m. Nursing Note indicated R160 was awake most hours of the night, at 3:44 a.m. writer and NAR went to assist her to bed, writer saw resident's catheter lying on the floor inflated. 10/23/18, 3:19 p.m. Nursing: Note indicated R160 refused to allow writer to re-insert her Foley catheter. Was very resistive. 11/4/18, 10:50 p.m. R160 started pulling catheter, taking out diapers, pulling G- tube, and	2 555		

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messing herself. R160 was fighting with the staff while cleaning and using inappropriate words.

11/8/18, 10:18 a.m. Nursing Note indicated staff attempted foley catheter change but were unsuccessful due to patient being combative.
During interview on 11/7/18, at 9:00 a.m.,with Registered Nurse (RN)-G, who complete MDS's, indicated she reviewed progress notes for very specific MDS items, and indicated R160 did not exhibit the specific behaviors. RN -G indicated if a resident started exhibiting behaviors between MDS assessments, then the nurse manager is responsible for updating the care plan.
On 11/7/18, at 9:15 a.m., RN-B verified R160 did not have any behaviors identified on the plan of care. RN-B stated R160 did exhibit behaviors.
On 11/7/18 at 9:23 a.m., Social Service (SS)-A indicated that nursing would add the specific behaviors to the plan of care.

Observation on 11/4/18, at 1:30 p.m., R160 was lying naked on the bed in her room, yelling at the nursing assistant to leave the door open. Surveyor asked the staff if R160 required 1:1 supervision and the staff stated "not always but right now because she was trying to take out her tubing."

Interview on 11/6/18, at 8:00 a.m. speech therapist (ST)-A indicated on days R160 is fatigued she does not eat well, and does not like to be fed. ST-A indicated R160 would take food from staff, but would push the staff's hands away when the staff attempted to feed her.

R11 had a diagnosis of lymphedema and a left above the knee amputation of the left leg

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indicated on the current order sheet. A quarterly MDS dated 10/26/18 indicated R11 had intact cognition.

The care plan dated 10/26/18 indicated R11 had limited physical mobility and directed staff to use a hoyer lift (mechanical lift device), however, the type of sling was not indicated.

During observation on 11/5/18, at 9:09 a.m. a full lift cross legged sling was under R11 while seated in the wheelchair. R11 stated the staff lost the multipurpose (amputee) sling last Wednesday (10/31/18) and were not able to find another one. She stated she felt scared and the sling hurts her on the back of her leg on the right side when she was transferred in the cross legged sling. During the observation an instruction sheet for the multipurpose (amputee) sling was observed posted in the resident's room.

On 11/5/18, at 11:20 a.m. the nurse manager RN-A stated the multipurpose (amputee) sling should be used for R11 and this sling was ordered for her. He verified that the aide group 5 care sheet (undated) noted for R11 "hoyer" for transfers but did not specify the type of sling. He also verified the comprehensive care plan did not indicate the type of sling to be used.

A physical therapy assessment dated 10/19/18, indicated the staff was to use the multipurpose (amputee)sling and lift posted information for the staff to follow in R11's room.

During an interview with NA-A on 11/6/18, at 7:10 a.m., she stated she was told the sling for R11 had gone to the laundry and the other cross

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2 555	Continued From page 16 legged sling was to be used. She stated she was trained not to use a cross legged sling for amputee residents and did not know if it was decided by a nurse to use it. She verified the cross legged sling had been used since last Wednesday. On 11/6/18, at 9:12 a.m. the director of nursing was interviewed and verified a cross legged sling should not be used for a full lift with a resident with an above the knee amputation. She stated the nurse should determine the type of sling and assure the resident was safely transferred in the full lift. She stated the care plan should reflect the assessed type of sling. The facility policy dated 10/2010, directed staff to review the resident care plan for special needs, and to use the needed equipment to safely transfer the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 555		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including	2 800		12/18/18

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2 800	Continued From page 17 registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement assistance with meals, and provide timely assistance with personal cares according to the residents' assessed need and as directed by the care plan. This practice had the potential to affect all residents who resided in the facility. Findings include: Refer to F677: The facility failed to ensure adequate grooming was provided to 1 of 5 residents (R31) who was dependent on staff for activities of daily living (ADL's). Refer to F684: The facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) for 1 of 1 resident (R108) reviewed for limitations in range of motion. Refer to F686: The facility failed to ensure 2 of 5 residents (R81, R31) identified at risk for pressure ulcers received timely repositioning. The failure of the facility to consistently implement a turning and positioning program resulted in actual harm, when R81 acquired three (3) new	2 800	Corrected.	

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stage II pressure ulcers (partial-thickness loss of skin with exposed dermis).

Refer to F690: The facility failed to provide timely toileting for 2 of 7 residents (R31, R81) reviewed for bowel and bladder. In addition, failed to ensure 1 of 7 residents (R224) received services and assistance to maintain bladder continence.

Resident interviews:

R9 was interviewed on 11/05/18, at 9:11 a.m. When asked about staffing R9 stated there was not enough aides. "It takes a long time to get help. Not too long ago, a couple of months ago, on the night shift at 3:00 a.m. I had a bowel movement and I got changed at 8:00 a.m. The aide said the call light had not come on. I put the call light on every 15 minutes, they come in turn off the light. Waiting beyond 30 minutes is too much time to wait to get help. I think they need a float person. When I first got here I was dizzy and needed more help. I still need assistance to go to the bathroom."

R219 was interviewed on 11/5/18, at 09:58 a.m. and indicated that "they are short on aides." They used to have 5-6 aides on the floor. One night there was one aide on the floor until someone could come in. Aides are working double shifts. Lots of aides have quit. They can't get me repositioned as frequently as I need. They take care of 12 people by themselves. They put new nurses on this floor and 4 nurses have quit since I was here. People from Florida bought this place and they do not care about us. I have had people who left in the middle of cares because they have said they have to go, their shift was done. I have

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complained to the nursing supervisor and she is now gone. My light will be on for 2 hours before they come in to turn me or bring me water. Staffing is a big problem. "

R11 and family member were interviewed 11/4/18 at 2:00 p.m. and stated the call lights are not answered timely, especially at night there are only 2 aides and would wait up to 2 hours for help and at times staff come into the room turned the call light off and stated they would be back but never did. During a follow up interview with R11 on 11/5/18 at 9:00 a.m., R11 stated she had been waiting since 5:00 a.m. to have a bath. R11 stated on several occasions she had brought complaints to registered nurse (RN)-A), who was the nurse manager, about staffing complaints and long call lights but it had not improved. R11 further stated the staffing levels were decreased to three aides on the unit about 3 months ago.

R184 was interviewed on 11/4/18 at 6:30 p.m. and stated there were concerns about waiting up to 4 hours to have a call light answered. R184 stated he had waited 4 hours last Friday after being incontinent of stool, and had complained to the nurse manager.

On 11/4/18, at 12:57 p.m. R451 stated the facility was very short staffed. R451 stated he had to wait two hours while sitting in stool, to get his incontinence product changed.

On 11/4/18, at 1:01 p.m. R227 stated her medications would be two hours late at times, and when she asked why, she was told staff were busy.

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On 11/4/18, at 1:30 p.m. R149 stated staffing was bad. R149 stated "I have had to wait two hours when I needed to be changed because I had a bowel movement in my brief."

On 11/4/18, at 2:35 p.m. R242 stated "I do not want to wait 30 minutes for assistance to walk to bathroom. They placed my walker across the room, so I would not go to the bathroom without help. I was not incontinent prior to admission."

On 11/4/18, at 3:07 p.m. R697 was lying in bed with oxygen on by a tracheostomy (an artificial opening in the neck to allow a patient to breath). There was a suction machine next to the window. R697 stated it was difficult to speak and requested to write her answers. R697 wrote,"They take too long to answer my call light. I have waited up to two and a half hours for someone to respond to my button [pointed at the call light]. This just doesn't happen once, it happens all the time." R697 wrote, "I could die if I wait too long. It scares me."

On 11/4/18, at 4:13 p.m. R202 stated when he put the call light on it would take the staff 45 minutes to come and put him on or off the commode. R202 stated he could do it himself but the staff wanted him to wait for assistance because he recently had his lower leg amputated.

On 11/4/18, at 4:20 p.m. when asked if he was getting the care and assistance he required, R151 stated "they are short of help here. They have cut the hours of the staff here and tell them to either leave an hour early or come late. So no one wants to stay and work here. You wait for an

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aide for one to two hours sometimes. Like I was supposed to be up at 4 p.m. and look am still in bed and no one has come to even let me know what is going on. Some nights it's only one aide and people here have to wait for that one person and they never come."

On 11/4/18, at 4:30 p.m. R173 stated the staff have too many patients, they are so busy. R173 stated "I have had to wait 30 to 45 minutes for my call light to be answered. I have been in pain and want a pain pill."

On 11/4/18, at 4:38 p.m. R170 stated "Sometimes I have to hold to go poop because there is no help anywhere. There are a lot of people but they walk around. I need to use the toilet with their help. That's the only thing I got to b**** about. They just need to train people on how to take care of people."

Staff Interviews:

On 11/4/18 at 2:15 p.m. nursing assistant (NA-A) stated the aides on the unit are assigned 13 residents, said there was not enough staff and thought the unit required 4 aides to meet the needs of the residents in the unit. At 2:40 p.m. when asked to assist R11, NA-A stated 2 aides were needed to use the lift which R11 used for transfers and she was the only aide on the unit yet for the afternoon shift.

On 11/4/18, at 6:50 p.m. licensed practical nurse (LPN)-F stated she worked on a different floor and had been floated to the floor. When asked about staffing LPN-F stated it was hard to get the

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work done at times because she had to help the NA's. When asked how she was able to identify the resident correctly when administering medication LPN-F stated she depended on the NA's to point out the residents.

On 11/4/18, at 4:18 p.m. registered nurse (RN)-L stated the 700 nurse did not come in so they were splitting the entire 700 hall between three nurses. RN-L stated there was one nursing assistant (NA) on the 500 hall and one on the 600 hall and a NA that floated between the two halls.

On 11/6/18, at 8:03 a.m. NA-C was interviewed after morning cares were done for R78. NA-C showed srveyor the work sheet and counted out loud he had 13 residents he was responsible for cares. NA-C stated he worked at his own pace and at times he had to wait for another NA to come in and assist him when he used the lift to transfer residents. When asked if he thought the unit 2SW had enough staff he just "laughed" and would not comment.

On 11/7/18, at 6:29 a.m. NA-L stated "you can just tell we are short." When you get home you are so tired because you will be running the whole day from room to room." NA-L stated management was aware and nothing had been done and yet the resident's in the unit needed more assistance and required two staff for cares and transfers.

On 11/7/18, at 1:30 p.m. anonymous staff indicated "It is about profit here. They don't care about the resident care. We seriously need the help here to provide the residents with quality

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care. They know but it's not a priority for management and the cooperation. Sometimes the residents are so helpless that you just don't know what to do or where to begin. You can attempt to fix the problems but they continue to come and just not enough help around here period."

On 11/8/18, at 10:26 a.m. LPN-G stated "they staff according to the census and sometimes we work okay and sometimes we work short. It can be difficult when we work short to get the work done because you have to help the nursing assistants and the residents." LPN-G stated at times resident would have to wait for a while to get the assistance because there was just nobody to help especially when a resident required two staff assistance with cares.

Resident observation:
On 11/6/18, at 6:58 a.m. R215 was overheard calling out "Hello change my diaper." LPN-D was observed down the hallway and was overheard state to nursing assistant (NA)-L "he needs help. When LPN-D returned to the nursing station where the medication cart was parked surveyor indicated R215 was calling out and LPN-D stated "I have told the aide."
-At 7:01 a.m. R215 continued calling out at this time registered nurse (RN)-K went into the room and R215 stated "change my diaper." RN-K then stated to R215 "someone is coming" as she left the came out of the room at the nursing station LPN-D stated "I have told [NA-L]."
-At 7:06 a.m. to 7:11 a.m. R215 started calling out "help me change my diaper" at this time RN-N and LPN-D were both standing at the medication carts which were located outside the

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nursing station across from R215's room.
-At 7:12 a.m. to 7:45 a.m. R215 was quiet and no staff went into the room.
-At 7:45 a.m. to 7:48 a.m. RN-N went into R215's room to give R215 medications and as she left R215 stated to her "Hi don't run away." RN-N turned around and approached R215 and R215 was overheard state in a loud voice strained voice "change my diaper." RN-N stated "change what" but R215 then stated "never mind" as RN-N left the room.
-At 7:49 a.m. surveyor told RN-N R215 was asking staff to change his incontinent pad. RN-N stated she did not understand what R215 wanted as he was heard to understand. RN-N stated she was going to find help.
-At 7:50 a.m. surveyor intervened and asked LPN-D when R215 was going to be assisted as it had been 50 minutes since R215's had asked. LPN-D stated she was going to find help.
-At 7:53 a.m. as RN-K and RN-N approached R215 he stated "what took so long."
-At 7:58 a.m. as NA-E and NA-L approached R215 yelled out "change my f****** diaper."
-At 7:59 a.m. NA-E was observed wipe stool off R215's bottom and stated R215's pad was dry.

On 11/6/18, at 8:07 a.m. RN-K stated "if help is needed it's provided." RN-K stated "when someone has to go he has to go."

Resident Council:

Review of the Resident council minutes for the past 3 months revealed on September 17, 2018 the council notified the new director of nursing of nursing concerns, and they would be filed on a

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concerns form.
The concern form was dated 10/8/18, indicated call lights were not being answered in a timely manner. The response from nursing was that nursing staff would be re-educated on using the call light pagers and on expectations.

During the resident council meeting held on 11/6/18 from 10:30 to 11:30 a.m. and was attended by seven residents and the ombudsman. R11 stated the council had submitted three grievances because they had been discussed in the council for several meetings and not resolved. The call light time response by nursing staff was the main grievance and it had been an ongoing issue. R40 stated the staff come in and ask what was needed, then turn off the light and said they will return "but they don't come back." R40 reported waiting two hours, and hearing others on the unit calling out for help. R61 stated they would have to turn the light on three times before getting help and this was common practice. R93 reported having the call light taken from residents when it was used to call for assistance. R93 stated he and other residents had waited a long time again the previous night on the night shift. R93 further reported wound treatments were not always completed as ordered. In additon, R61, R40, and R93 reported passing bedtime snacks was not always done because there were not enough aides on duty.

During the resident council meeting the members in attendance expressed a concern that comments they were bring up in the council meetings about staffing issues did not get written into the minutes, and a response was not given

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to the council on efforts to solve the problem.

System:
Call light audits for the second floor north unit were reviewed for the month of October 2018, the audit was for 14 residents and included 47 episodes of the call lights being on for 60 minutes or more. The assistant adminstrator was interviewed on 11/7/18 at 1:06 p.m., and stated they had audited a few residents on 2 north for the past 3 months. She stated she did not investigate call light times greater than an hour for resident issues but did see which aide was assigned. She stated the audit was not able to track instances when an aide would turn off the light and return later to meet the resident's need. She stated she was aware of the resident council concerns about staffing and had talked to them but offered no written response. She stated the new policy to have aides carry a pager with them to indicate a call light was on started in September 2018.

Interview with the staffing coordinator on 11/7/18 at 2:33 p.m. if staff call in will attempt to fill the need and if not will make administration aware.

The policy for the nursing staff to carry pagers was identified in a memo dated 9/7/18 which indicated all staff were to sign out and carry a pager to be aware of the call lights. The current call light system had a banner on the unit which ran the room numbers of call lights activated and the pager would also sound to alert staff.
The sign out sheets for the second floor for 11/2/18, 11/3/18, 11/5/18, and 11/6 18 had none of the pagers signed out for the evening and night shift, and 3 signed out on the day shift. The

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2 800	Continued From page 27 RN-A verified that the day and evening shifts would have 6 staff on them. On 11/8/18, at 2:36 p.m. during an interview with the administrator, the director of nursing and the intern administrator, the administrator stated the facility was being staffed by acuity and transfers. When asked about the observations of staff not repositioning residents, not toileting residents timely and providing the services and care needs both stated some of the staff who were involved in the situations had been let go as this was not acceptable standards. The facility assessment dated 7/23/18 indicated the needs of residents, past survey performance, and determined they had sufficient staffing. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		

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2 830	Continued From page 28	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide therapeutic diets as ordered by the physician for 2 of 4 residents (R115, R83) reviewed for dining. In addition, The facility failed to utilize the appropriate mechanical lift sling for 1 of 2 resdients (R11) reviewed for accidents. Findings include: R115's quarterly minimum data set (MDS) dated 9/4/18, indicated he was moderately cognitively impaired and required supervision while eating after meal set up. R115's care plan dated 10/2/18, indicated a potential nutrition/hydration problem related to a mechanically altered diet, coughing with meals and weight loss. R115's Order Summary Report identified a physican's	2 830	Corrected.	12/18/18

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order dated 9/19/18, for a mechanical soft, ground texture diet with nectar thick liquids.

R83's quarterly MDS dated 6/31/18, indicated he was severely cognitively impaired and required supervision and physical assistance to eat. R83's Order Summary Report identified a physican's order dated 12/13/17, for a mechanical soft, chopped texture diet. The order indicated R83 may request regular texture meals and directed staff to cut meat into small pieces. R83's care plan dated 9/1/18, identified a dysphagia (difficulty in swallowing) diagnosis and a diet of mechanical soft food.

During observation on 11/4/18, at 5:24 p.m. R115 was in the dining room during the evening meal. R115, along with all other residents on a mechanical soft diet were served pureed food.

During interview at 5:33 p.m. Dietary aide (DA)-A stated she was not sure what the residents on a mechanical soft diet could eat so she served them all pureed food.

At 5:56 p.m. R115 received a meal of pureed food even though his diet slip identified a mechanical soft diet. R115 did not eat his meal.

During observation on 11/6/18, at 12:29 p.m. R83 was seated at a table in the dining room awaiting his noon meal. At 12:30 p.m. R83 requested a corn dog. DA-B served a corn dog, chopped up as directed by R83's diet. Nursing assistant (NA)-C returned the plate to DA-B and stated R83 would not eat the chopped up food and requested two whole corn dogs. She stated R83 would "get mad" if she served the chopped

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food. NA-C served the whole corn dogs to R83 and left the table.

During interview at 12:37 p.m. DA-B stated she gave R83 the right meal but NA-C told her to give him whole corn dogs so she did what NA-B asked.

At 12:38 p.m. NA-C stated R83 would not take the chopped up food, even though she had not offered it to him. She stated if she would have offered it, "it would have been a problem." She stated she thought the dietician knew about it.

At 12:40 p.m. registered nurse (RN)-K was alerted the wrong diet had been served. RN-K state the NA's were "absolutely" not allowed to upgrade a residents diet. She stated staff should be following the diet slip. RN-K did not remove the incorrect food consistency from R83.

During interview on 11/6/18, at 12:45 p.m. registered dietician (RD)-A stated nursing assistants were not allowed to upgrade a residents diet. RD-A reviewed R83's care plan and stated staff were to monitor for difficulty with chewing and swallowing. RD-A stated the care plan did not contain any modifications to R83's diet and did not contain any risks and benefits related to not following his prescribed diet. RD-A made no attempt to take the incorrect food from R83. When asked about the differences in the chopped and ground diets, RD-A stated if a resident was on a ground diet they could only have pureed bread.

During observation on 11/7/18, at 8:44 a.m. R115 was served eggs with cheese and regular

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toast. In addition, R115 was served thin liquids of milk and juice. R115 had eaten all of the toast and drank some of the milk and all of the juice, and was observed coughing at the table.

At 8:50 a.m. RN-I verified the incorrect diet had been served to R115. RN-I removed the remaining thin liquids. RN-I stated all staff in the dining room should be aware of the residents diet and were responsible to ensure the correct food was served.

During interview on 11/7/18, at 9:09 a.m. DA-B stated the aides tell her what they want her to serve and stated, "that;s what i give." When asked about the toast for a mechanical ground diet, DA-B stated, "pureed, I think. It's written here somewhere. Maybe you should ask the dietician."

During interview on 11/8/18, at 10:28 a.m. the director of dietary services (DDS) stated she had heard about the diet concerns on the third floor. The DDS stated staff received training related to food safety and diet and should know what food to serve. She stated the dietary aide should not give food that was not on the diet order. The DDS stated she rounded in the dining rooms during meal service but did not conduct any formal audits to ensure meals were provided as directed by the physicians order.

On 11/8/18, at 1:36 p.m. the director of nursing (DON) stated she had heard staff were giving incorrect diets. The DON stated nursing and dietary staff were responsible for ensuring the correct diet was served.

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A facility policy titled Accidents and Incidents - Investigating and Reporting dated April 2010, indicated all accidents or incidents involving residents, etc shalt be investigated and reported to the administrator. The nurse manager or supervisor shall promptly initiate and document investigation of the accident or incident.

R11 had a diagnosis of lymphedema and a left above the knee amputation on the left leg.

A quarterly minimum data assessment (MDS) dated 10/26/18 indicated a brief inventory of mental status (BIMS) of 15 which indicated R11 was cognitively intact for memory. The care plan dated 10/26/18 indicated R11 had limited physical mobility and directed staff to use a hoyer lift (mechanical lift device), the type of sling was not indicated.

During observation on 11/5/18, at 9:09 a.m. a full lift cross legged sling was under R11 while seated in the wheelchair. R11 stated the staff lost the multipurpose (amputee) sling last Wednesday (10/31/18) and were not able to find another one. She stated she feels scared and the sling hurts her on the back of her leg on the right side when she was transferred in the cross legged sling. An instruction sheet for the multipurpose (amputee) sling was observed posted in the resident's room.

On 11/5/18, at 11:20 a.m. the nurse manager (RN-A) stated the multipurpose (amputee) sling should be used for R11 and this sling was ordered for her. RN-A was not aware that a cross legged sling was in use. RN-A verified that a cross-legged sling should not be used with a

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resident that had an above the knee amputation, and was not sure if the aides or a nurse had changed the sling. He verified that the aide group 5 care sheet (undated) noted for R11 "hoyer" for transfers but did not specify the type of sling. During an interview on 11/6/18. at 8:15 a.m., RN-A stated that nursing did not do an assessment for the type of sling to be used, that was done by the therapy department.

A physical therapy assessment dated 10/19/18, indicated the staff was to use the multipurpose (amputee)sling and left posted information for the staff to follow in the resident's room.

On 11/5/18, 11:15 a.m. during an interview with the education nurse, she stated nursing assistants (NA)'s were trained with the cross legged sling and not a cradle or amputee sling. She stated no training had been done with NA's about which sling was to be used, this would be the nurse's decision.

During an observation on 11/5/18, at 2:38 p.m. a cradle full body sling was observed in the room.

During an observation on 11/6/18, at 8:30 a.m., R11 was transferred by NA-A and NA-J in a full lift and a cross legged sling which had been under R11 in the wheelchair. R11 was transferred from the wheelchair to the bed as R11 was raised up in the lift, R11 was off center and leaning to the left. The cross leg straps were in 2 different area on her legs, and R11 complained of discomfort.

During an interview with NA- A on 11/6/18, at 7:10 a.m., she stated she was told that the sling

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for R11 had gone to the laundry and the other cross legged sling was to be used. She stated that she was trained not to use a cross legged sling for amputee residents and didn't know if it was decided by a nurse to use it. She verified that the cross legged sling had been in use since last Wednesday.

An interview with RN-A on 11/6/18, at 8:48 a.m. revealed that R11 was brought a cradle lift sling the day before and RN-A observed that the staff transferred R11 safely. RN-A was aware R11 that now had the cross legged sling and it had been replaced on overnight shift because R11 requested.

Review of progress notes on 11/5/18, and 11/6/18, there was no note on change of sling, reassessment or notice to resident of the risks and benefits for the use of a cross legged sling. RN-A stated the risks and benefits of refusing the cradle sling were not documented yet .

On 11/6/18, at 9:12 a.m. the director of nursing was interviewed and verified that a cross legged sling should not be used for a full lift with a resident with an above the knee amputation. She stated the nurse should determine the type of sling and assure the resident was safely transferred in the full lift.

The manufacturer's recommendations for use of slings for amputee residents included a multipurpose or hourglass sling. A multipurpose sling did not cross between the resident's legs.

The facility policy dated 10/2010, directed staff to review the resident care plan for special needs,

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2 830	Continued From page 35 and to use the needed equipment to safely transfer the resident. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise as necessary the policies and procedures related to mechanical lift transfers and therapeutic diets. The DON or designee could provide training for all appropriate staff on these policies and procedures. The quality assessment and assurance committee could do random audits of transfers to ensure compliance and complete dining room audits to ensure proper delivery of prescribed diets. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to ensure shaving and clean clothing was provided to 1 of 5 residents (R31) who was dependent on activities of daily living (ADL's) Findings include:	2 850	Corrected.	12/18/18

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R31's diagnoses included aphasia, dementia and hemiplegia obtained from the quarterly Minimum Data Set (MDS) dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required physical extensive assistance of one to two staff with getting dressed and personal hygiene.

R31's care plan dated 11/2/18, identified R31 had an ADL deficit related to right hemiplegia, dementia and decreased mobility. The care plan directed staff to provide assistance of one staff with personal hygiene.

On 11/4/18, 5:37 p.m. R31 was observed seated on the wheelchair in the dining room and was noted to have scruffy facial hair. When asked how he was R31 did not respond and looked away.

On 11/5/18, at 9:53 a.m. R31 was observed by the front nursing station dressed up and the scruffy facial hair remained.

On 11/5/18, at 10:15 a.m. during a telephone interview when asked if R31 received assistance with ADL's family member (FM)-A stated staff did not make sure R31 had clean clothes and R31 was not shaved daily. FM-A stated when R31 was able to take care of himself he shaved daily and took pride in making sure he was well groomed, clean and "self respected himself."

On 11/6/18, at 1:20 p.m. FM-A was observed standing beside R31 in the television lounge area. When approached R31 was observed still

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2 850	Continued From page 37 with scruffy facial hair and around his mouth was dried food and the shirt had both dried and wet spills of food. When approached FM-A stated he had just arrived at the facility to find R31 that way and was frustrated with the staff with not making sure R31 was well groomed and had clean clothing. FM-A stated the family had brought in a shaver but did not know where it was and if and when they shaved R31 as R31 was not well kept most of the time. On 11/6/18, at 2:29 p.m. registered nurse (RN)-K verified R31 was unshaved, had food around his mouth and the shirt on the front left side had dried and wet yellow food spills. RN-K stated she would have R31 cleaned right away. RN-K further stated all residents were supposed to be assisted with cares and staff were to make sure residents were cleaned properly after meals and were well groomed as she reminded staff all the time. On 11/7/18, at 2:26 p.m. the director of nursing stated residents were supposed to be provided cares as directed by the care plan and residents were supposed to be well groomed and have clean clothing. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one	2 850		

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2 850	Continued From page 38 (21) days.	2 850		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to prevent a decrease or maintain range of motion (ROM) for 1 of 1 resident (R108) reviewed for limitations in range of motion. Findings include: R108's diagnoses included left hand and wrist contracture, hemiplegia, muscle weakness and dementia obtained from the quarterly Minimum Data Set (MDS) dated 9/7/18. In addition, the MDS indicated R108 had functional limitation in range motion of one side on his upper and lower extremity.	2 895	Corrected.	12/18/18

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2 895	Continued From page 39	2 895		

R108's care plan dated 9/1/18, indicated R108 had limited physical mobility related to a cerebrovascular accident (CVA) with left hemiplegia. The care plan directed staff to provide gentle ROM as tolerated with daily care. The care plan also indicated R108 frequently refused but staff were to attempt to provide the ROM to the left upper extremity, hand and wrist. The care plan further indicated R108 was to wear a palm protector in the left hand as tolerated and indicated it was okay to remove the palm protector for skin care, bathing and per R108's request.

On 11/4/16, from 4:42 p.m. to 7:09 p.m. R108's left arm rested against his abdomen with the fingers of his left hand tightly clenched into a closed fist. There was no splint or rolled wash cloth in place in R108's left hand. When R108 was asked if he could open his hand and stretch out his fingers he stated it hurts.

On 11/5/18, from 10:00 a.m. to 1:20 p.m. R108's left arm was observed resting on a armrest attached to the wheelchair. His left hand was tightly clenched into a fist. There was no splint or rolled wash cloth in place in R108's left hand during the observation.

On 11/6/18, from 9:40 a.m. to 10:03 a.m. nursing assistant (NA)-E and registered nurse (RN)-K provided R108 morning care. They did not offer or provide ROM, nor was the palm protector applied to the left contracted hand. From 10:03 a.m. to 10:55 a.m. NA-E and licensed practical nurse (LPN)-D applied cream to R108's body, shaved him and applied a light

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2 895	Continued From page 40	2 895		

sweat shirt but neither of them offered the hand palm protector for the left contracted hand nor offered passive ROM.

On 11/6/18, at 1:50 p.m. LPN-D verified the left hand palm protector had not been offered or applied to R108. LPN-D also verified she had signed it off on the treatment administration record as she thought NA-E had applied it. LPN-D then stated she was going to apply the palm proctor to R108's left contracture. At 1:58 p.m. NA-E approached R108 and applied the palm protector and R108 did not refuse.

-At 1:59 p.m. NA-E stated R108 was supposed to have the palm protector on the left contracted hand but he forgot to apply it that morning because he had a lot to do. NA-E further acknowledged he had not offered or completed ROM that shift.

-At 2:00 p.m. LPN-D stated NA-E was supposed to do passive ROM or at least offer and if R108 refused he was supposed to let her know.

On 11/8/18, at 12:35 p.m. RN-I stated the NA's were supposed to complete ROM and apply the palm protector as directed by the care plan and the assignment sheet. Surveyor requested a copy of the ROM documentation/charting.

On 11/8/18, at 4:30 p.m. no ROM documentation was provided.

The Range of Motion Exercise policy revised October 2010, directed staff to document in the medical record the date, time, the type of ROM (active or passive) and how long the exercise

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2 895	Continued From page 41 was conducted. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for contractures to assure they are receiving the necessary treatment/services to prevent contractures. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for contracture development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		12/18/18

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Based on observation, interview and document review, the facility failed to ensure 2 of 5 residents (R81, R31) identified at risk for pressure ulcers received timely repositioning. The failure of the facility to consistently implement a turning and positioning program resulted in actual harm, when R81 acquired three (3) new stage II pressure ulcers (partial-thickness loss of skin with exposed dermis).

Corrected.

Findings include:

R81 did not receive a position change on 11/7/18, for over three hours and acquired three new, stage II, pressure ulcers.

R81's quarterly minimum data set (MDS) assessment dated 8/30/18, identified diagnoses including: dementia with Lewy bodies, Alzheimer's disease, muscle weakness neuromuscular dysfunction of bladder, and peripheral vascular disease. The MDS indicated R31 had severely impaired cognition and required physical assistance of two staff with toileting, bed mobility and transfers. The MDS further indicated R31 was frequently incontinent of cares, and had no refusal of care behaviors.

R81's care plan dated 9/12/18, identified a risk for impaired skin integrity related to fragile skin and incontinence. The care plan indicated R81 had a history of a pressure ulcer on the coccyx and had a potential for pressure ulcer development related to immobility and incontinence. The care plan further indicated R81 had a stage 2 pressure ulcer to the coccyx and left buttocks. The care plan directed staff to assess and complete treatments to the pressure

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2 900		2 900		

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areas on the coccyx and left buttocks. The care plan directed staff to provide assistance with turning and repositioning at least every 2 hours and more often as needed.

On 11/5/18, at 9:58 a.m. when asked if R81 had any pressure ulcers, family member (FM)-B stated "yes." FM-B also stated the pressure "sores" were on the buttocks, that R81 was not changed often enough, and that R81 was left to sit on her buttocks "for a long time."

During continuous observation on 11/7/18, from 6:25 a.m. to 9:54 a.m., the following observations were made: R81 was observed to lay on the backside in bed sleeping. At 7:50 a.m. nursing assistant (NA)-F went past R81's room but did not offer repositioning. At 9:40 a.m. R81 remained asleep on the backside with no attempts by staff to reposition (3 hours and 15 minutes), at which time the surveyor intervened and alerted licensed practical nurse (LPN)-E.

Nursing assistant (NA)-F was interviewed on 11/7/18 at 9:44 a.m. NA-F stated he did not know the last time R81 had been repositioned as he had come in late that morning. At 9:52 a.m., NA-F approached R81 and cued her they were going to check, change and reposition her. At 9:54 a.m. (3 hours and 29 minutes after last repositioning), NA-F and NA-M turned R81 to the left side. R81's incontinent pad was saturated with urine and three open bleeding areas were noted on R81's left lower buttock, with two other areas on the right buttock. In addition, a foam dressing was observed around the coccyx.

At 10:02 a.m. on 11/7/18, LPN-E was observed

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2 900	Continued From page 44	2 900		

to remove the old dressing revealing an open area to the coccyx. LPN-E measured the three bleeding wounds and stated she was going to let the nurse manager know about them. LPN-E said in the meantime, she was going to apply a foam dressing until the physician could be contacted to obtain a treatment for the other open areas. At 10:05 a.m. LPN-E stated she would have expected R81 to have been turned and repositioned according to the care plan. She said if the NAs were not able to complete repositioning in a timely manner, they were supposed to let her know.

During a follow up interview with NA-F at 10:30 a.m. on 11/7/18, NA-F stated he did not know he was assigned to R81 until the surveyor had asked about it.

On 11/7/18, after concern was brought to the facility attention, a progress note dated 11/7/18, at 8:57 p.m. indicated the following::
"Resident noted with three new small stage 2 pressure wounds on the coccyx" The areas were measured as: 1.1 cm (centimeter) by 0.5 cm by 0.1 cm; 2.3 cm by 1.4 cm by 0.1 cm; and 1.1 cm by 0.8 cm by 0.1 cm; and one stage 2 wound on the left buttock measuring: 1.2 cm by 0.6 cm by 0.1 cm; and four small stage 2 pressure areas on the right buttock measuring 0.5 cm by 0.5 cm by 0.1 cm; 0.8 cm by 0.5 cm by 0.1 cm; 0.2 cm by 0.2 cm by 0.1 cm; and 0.3 cm by 0.2 cm by 0.1 cm. The note also indicated: "Resident also has a reddened blanchable area measuring 16 cm by 14 cm by 0.1 cm ..."

During review of the Nursing Daily Pressure

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Injury Documentation dated 11/4/18, 11/2/18, 11/1/18, and 10/31/18, it was revealed that on all four dates the coccyx had been identified to have an open area. On 11/1/18, the assessment had indicated there was an open area on the left buttock. The documentation lacked staging, size, drainage color, odor and approximate amount, pain if present, nor did it include assessment of the wound bed to include the color and type of tissue/character and a description of wound edges and surrounding tissue.

On 11/7/18, at 10:24 a.m. when asked about the wound documentation, registered nurse (RN)-K stated for the past few weeks the floor nurses had been doing the wound rounds for her. RN-K stated they were supposed to complete the documentation. RN-K verified the medical record lacked documentation related to staging, size, drainage color, odor and approximate amount, pain if present, wound bed including the color and type of tissue/character and a description of wound edges and surrounding tissue.

On 11/7/18, at 1:56 p.m. RN-I stated he was not familiar with R81 however, after reviewing the care plan he stated the minimum expectation was R81 would be repositioned every two hours as she was at risk for pressure ulcers and already had a current pressure ulcer.

On 11/7/18, at 2:02 p.m. RN-I reviewed the actual working schedule and verified R81 had been assigned to NA-F's team from the beginning of the shift. RN-I stated there was no reason NA-F should have been confused about being assigned to assist R81.

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On 11/8/18, at 2:02 p.m. the director of nursing (DON) stated she had been at the facility for less than two months and was in the process of working on various care concerns. The DON stated wound assessments were something the clinical coordinators were working on as well as having the whole interdisciplinary team round. The DON further stated residents who were at risk for pressure ulcers were supposed to be repositioned at least every two hours or as directed by the care plan.

The facility's Skin Integrity, Pressure Injuries, Nursing Protocol policy revised November 2017, indicated: "The resident will receive care, consistent with professional standards of practice to prevent pressure injuries and will not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and the resident with pressure injuries will receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing..."

R31's quarterly MDS dated 8/8/18 indicated the resident had diagnoses including: aphasia, dementia and hemiplegia. The MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and required total physical assistance of two staff with toileting, bed mobility and transfers. The MDS further identified R31 had not walked during the assessment period and was at risk for pressure ulcer development.

R31's care plan dated 11/2/18, identified a risk

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for skin breakdown due to bladder and bowel incontinence, cognitive loss and decreased mobility. The care plan directed staff to offer repositioning every two hours and as needed.

On 11/7/18, R31 was continuously observed from 6:25 a.m. unit 11:34 a.m. (5 hours and 9 minutes). At 7:50 a.m. nursing assistant (NA)-F approached R31, tilted the wheelchair back and left R31 in the television lounge. At 8:41 a.m. the registered dietician (RD) wheeled R31 to the dining room table. R41 ate and was assisted directly to the main dining room for an activity where he remained until 11:20 a.m. when the surveyor intervened. At 11:20 a.m., NA-F stated when he came to the unit at 7:50 a.m. he had noticed R31 in the television lounge and had tilted the wheelchair back and at the same time had uncrossed R31's legs. When asked if that was an appropriate form of repositioning, NA-F stated it was and indicated it helped a resident change positions. NA-F stated he did not know when R31 had been repositioned last as the night shift had gotten him up. At 11:40 a.m., NA-F and NA-I were observed to use a mechanical lift to get R31 onto the bed. R31's brief was observed to be wet from urine.

On 11/7/18, at 2:02 p.m. registered nurse (RN)-I stated a resident had to have tissue relief of at least two minutes for it to be considered repositioning, which meant a resident had to be off- loaded from the surface. RN-I verified R31 was on an every two hour repositioning schedule and staff were supposed to follow the care plan.

On 11/7/18, at 2:26 p.m. the DON stated residents who were at risk for pressure ulcers

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2 900	Continued From page 48 were supposed to be repositioned at least every two hours or as directed by the care plan. When asked what she considered to be appropriate repositioning, the DON stated a resident needed to be off- loaded from the surface. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as	2 910		12/18/18

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2 910	Continued From page 49 much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting for 2 of 7 residents (R31, R81) reviewed for bowel and bladder. In addition, failed to ensure 1 of 7 residents (R224) received services and assistance to maintain bladder continence. Findings include: R224 Admission Record indicated she was admitted on 8/3/18, with diagnosis including weakness, essential hypertension, type 2 diabetes, morbid obesity, chronic atrial fibrillation, and major depressive disorder. Review of Minimum Date Set (MDS) dated 10/24/18, indicated R224 was frequently incontinent of bladder. Review of R224's plan of care dated 9/17/18, indicated R224 had "episodes of bladder and bowel incontinence", with interventions that included assisting her to the bathroom every two hours and as needed and to provide peri-care and management of pad/clothing. Review of the Nursing 3 day voiding/ bowel movement evaluation dated 9/4/18, indicated "based upon the 3 day trial, is the resident continent. with the answer of yes," and that based upon the voiding diary, is the resident a candidate for : no retraining. Review of the	2 910	Corrected.	

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Bladder Incontinence Evaluation dated 10/8/18, indicated R224 had urinary frequency that was not of recent onset.

During interview on 11/05/18, at 1:30 p.m., R224 indicated she was continent of bladder at home with a small pad but after her catheter was removed in the facility, the staff told her to "go in her diaper" R224 indicated she had never been offered the commode or assistance into the bathroom and would tell the staff after she went to the bathroom in "her diaper."

On 11/7/18, at 10:00 a.m., registered nurse (RN)-B indicated she would talk to R224 to see who had told her to "go in her diaper" and stated when a urinary catheter was discontinued, a three day assessment was completed and retraining should have been attempted, and verified R224 lacked retraining after the urinary catheter was removed.

R31's diagnoses included aphasia, dementia and hemiplegia, obtained from the quarterly MDS dated 8/8/18. In addition the MDS indicated R31 had severely impaired cognition, had both short and long term memory problems and was totally dependent on two staff for toileting and transfers. The MDS further identified R31 was always incontinent of bladder and bowel and was not on a toileting program.

R31's care plan dated 11/2/18, identified incontinence of bladder and bowel related to hemiplegia, dementia and decreased mobility. The care plan directed staff to assist R31 to lay down via a mechanical lift to check and change incontinent product upon rising, after meals,

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2 910	Continued From page 51	2 910		

before bed and as needed.

On 11/7/18, R31 was continuously observed from 6:25 a.m. unit 11:34 a.m. (5 hours and 9 minutes). At 7:50 a.m. nursing assistant (NA)-F approached R31 from the back, tilted the wheelchair back and left R31 in the television lounge. At 8:41 a.m. the registered dietician (RD) wheeled R31 in his wheelchair to the dining room table. R31 remained in the dining room until 10:00 a.m. when staff wheeled him to the main dining room for an activity. R31 remained in the activity until 11:20 a.m. when surveyor intervened. At 11:20 a.m. NA-F stated when he came to the unit at 7:50 a.m., he had noticed R31 in the television lounge and had tilted the wheelchair back and at the same time he uncrossed R31's legs. NA-F confirmed he had not checked and changed R31 after breakfast. At 11:40 a.m. NA-F brought R31 into the room, and with assistance from NA-I, used a mechanical lift to get R31 onto the bed. R31's brief was saturated with urine.

R81's diagnoses included dementia with Lewy bodies, Alzheimer's disease, muscle weakness and neuromuscular dysfunction of bladder, obtained from the quarterly MDS dated 8/30/18. In addition the MDS indicated R31 had severely impaired cognition and required physical assistance of two staff with toileting, bed mobility and transfers. The MDS further indicated R31 did not refuse cares and was frequently incontinent of bladder and bowel.

R81's care plan dated 9/12/18, identified R81 was incontinent of bladder and bowel related to

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2 910	Continued From page 52	2 910		

immobility, obesity, congestive heart failure and dementia. The care plan directed staff check brief on rising, after meals, at bedtime hours and as needed.

On 11/7/18, R81 was continuously observed from 6:25 a.m. to 9:54 a.m. (3 hours and 15 minutes). During the observation no staff went to R81's room until at 9:40 a.m. when surveyor approached licensed practical nurse (LPN)-E and indicated R81 had not been checked and changed since 6:25 a.m.

At 9:44 a.m. nursing assistant (NA)-F stated he did not know the last time R81 had been checked and changed as he had come in late that morning. At 9:52 a.m. NA-F approached R81 and cued her they were going to check, change and reposition her and R81 stated "yes." At 9:54 a.m. which was 3 hours and 29 minutes of continuous observation NA-F and NA-M turned R81 to the left side. R81's incontinent pad was saturated with urine and her skin was visibly wet.

At 10:05 a.m. LPN-E stated she would have expected the NA's to turn, reposition and toilet R81 according to the care plan and if they were not able to get it completed timely they were supposed to let her know.

At 10:30 a.m. NA-F stated he did not know he was assigned to R81 until surveyor asked about it.

On 11/7/18, at 2:02 p.m. RN-I reviewed the actual working schedule and verified R81 was assigned to NA-F's team from the beginning of

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2 910	Continued From page 53 the shift. RN-I stated there was no reason NA-F was confused if he was assigned to assist R81. On 11/7/18, at 2:02 p.m. registered nurse (RN)-I stated residents were supposed to be toileted as directed by the care plan. On 11/7/18, at 2:26 p.m. the director of nursing (DON) stated all resident's who required to be checked and changed were supposed to be provided cares as directed by the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing could review/revise bowel and bladder assessment policies and procedures, educate staff, and then audit to ensure compliance. The director of nursing will ensure staff are educated and audit to ensure residents are toileted as directed by the care plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed ensure food stored in refrigerators was properly dated and labeled in 4	21015	Corrected.	12/18/18

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of 6 refrigerators and failed to ensure 5 of 6 refrigerators, 1 of 1 freezer, 1 of 2 microwaves, 2 of 2 stainless steel storage cabinets, and 1 of 2 cereal carts were clean.

Findings include:

On 11/04/18, at 11:48 a.m. the initial tour of the kitchen and kitchenette was conducted with the executive chef (EC). The walk in freezer did not have a thermometer on the inside. The EC got one right away and placed it in the freezer. On the floor of the walk in freezer were pieces of paper debris. In the walk in cooler there was an open bag of hard boiled eggs that was not marked with the date open. There was also a meat sandwich wrapped in plastic wrap that was not marked with the date prepared. The floor of the walk in cooler had debris and smears of dark gray substance on the floor. The EC was asked how often the floors were swept and mopped. The EC was unsure, but another kitchen staff member stated the staff tried to sweep and mop it twice a week.

At 11:59 a.m. a second walk in freezer was inspected and the floor of that freezer was dirty. In the kitchen there were two metal storage cabinets for kitchen equipment, bowls, and utensils. Both cabinets had debris on the all the shelves and smears of grease or a white substance on the outside of the doors.

Immediately following the main kitchen the 2 west kitchenette was inspected with the EC. A stack of pre-sliced cheese was loosely wrapped in plastic wrap. The plastic wrap was not sealed and the cheese was exposed to the air. The

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cheese was not marked with the date it was placed in the refrigerator. An undated Magic Cup Nutritional Supplement was in the refrigerator. The label indicated the Magic Cup could only be kept for 3 days after thawing. There was no date on the container indicating when it was removed from the freezer and placed in the refrigerator. The bottom of the refrigerator was covered with a red juice spill. A cart holding the dry cereal dispensers was covered with pieces of cereal around the dispenser on the top shelf. On the second shelf there was debris and dust.

At 12:36 p.m. the kitchenette on 3 west was inspected. There was an open bag of Sysco Raisins that were not dated when opened. The interior bottom of the refrigerator was full of juice spills.

At 12:45 p.m. the Bridgeway front kitchenette was inspected. A carton of med pass 2.0 nectar thick supplement drink was open and undated. The microwave had a used paper towel on the turn table and food splatters on the door.

At 4:54 p.m. with cook (C)-A the Bridgeway back kitchenette refrigerator was inspected. On the third shelf in the back was a dish of fruit that was not dated. C-A put the dish in the dirty dish rack. The inside of the refrigerator was also dirty with juice spills. C-A stated housekeeping was responsible for cleaning the refrigerators.

On 11/06/18, at 10:08 a.m. a second tour of the kitchen and kitchenettes was conducted with the dietary director (DD). In the main kitchen walk in freezer there were five tator tots on the floor and on the plastic flap hanging in the door of the

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freezer there was a orange brown substance smeared on the plastic. The DD stated the food needed to be cleaned off the plastic and the floor of the freezer and walking coolers should be swept and washed daily. The floor of the walk-in cooler was still dirty and had paper scraps on it. The two metal cabinets were still smears on the front and had debris on the shelves. The DD stated all food going into the refrigerator or freezer needs covered appropriately and marked with the date open or expiration date. The DD added the staff was responsible for making sure the food was labeled and dated appropriately. The kitchenettes were inspected immediately after the kitchen. The 2 west kitchenette refrigerator still had juice spills on the inside bottom and the cart with the dry cereal dispensers was still covered with cereal crumbs, dust and debris. The 3 west kitchenette refrigerator was still dirty with juice spills on the inside. The refrigerators on Bridgeway Front and Back still contained juice spills.

On 11/7/18, at 2:23 p.m. the DD stated the kitchen staff was responsible for the cleaning of the refrigerators. She stated there was a schedule for that process, but the staff had not been following it. The DD stated the kitchen staff were responsible for the cleaning of the kitchen areas and refrigerators. The DD also stated the kitchen staff were responsible for making sure all open food got marked with the date it was opened or used by date.

A policy for cleaning of the refrigerators was requested, but not received.

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21015	Continued From page 57 SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		12/18/18

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This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to have a program in place to read Mantoux's for residents in a consistent manner to ensure resident's Mantoux's were read in the correct time frame after receiving their Mantoux's for steps one and two. The lack of a consistent program for reading resident's Mantoux's affected 5 of 5 residents (R213, R225, R178, R241, R147) whose Mantoux's were reviewed. In addition, one of five residents (R147) reviewed did not have a two step Mantoux.

Corrected.

Findings include:

Five random residents were reviewed for Tuberculosis screening. Five of five residents did not have times when steps one and two were read. R147 did not have a two step Mantoux completed. R241 received step on one day and then the Mantoux was read the following day not leaving enough time for a correct reading of the Mantoux.

R213 was admitted to the facility on 8/25/17. R213 was screened for signs and symptoms of tuberculosis on 9/11/18. R213 had the first step Mantoux on 9/11/18, no time documented when given and was read on 9/12/18, there was no documentation when read. Results of the step 1 Mantoux were negative and 0.0 indentation. The second step Mantoux was done on 9/24/18 at 4:00 p.m. and read on 9/26/18, there was no documented time when read. The results of the second step Mantoux were negative and 0.0

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induration.

R225 was admitted to the facility on 11/27/17. R225 was screened for signs and symptoms of tuberculosis on 11/29/17. R225 had the first step Mantoux on 12/12/17, at 2:00 p.m. and read on 12/14/17, there was no documentation when read. Results of the step 1 Mantoux were negative and 0.0 indentation. The second step Mantoux was done on 12/26/17, at 12:00 p.m. and read on 12/28/17, there was no documented time when read. The results of the second step Mantoux were negative and 0.0 induration.

R178 was admitted to the facility on 1/5/18. R178 was screened for signs and symptoms of tuberculosis on 2/23/18. R178 had the first step Mantoux on 2/23/18, at 7:30 p.m. and read on 2/25/18, there was no documentation when read. Results of the step 1 Mantoux were negative and 0.0 indentation. The second step Mantoux was done on 3/9/18, at 9:19 p.m. and read on 3/11/18, there was no documented time when read. The results of the second step Mantoux were negative and 0.0 induration.

R241 was admitted to the facility on 9/24/18. R241 was screened for signs and symptoms of tuberculosis on 9/24/18. R241 had the first step Mantoux on 9/24/18, at 3:00 p.m. and read on 9/25/18, there was no documentation when read. Results of the step 1 Mantoux were negative and 0.0 indentation. The second step Mantoux was done on 10/9/18, at 6:45 p.m. and read on 10/11/18, there was no documented time when read. The results of the second step Mantoux were negative and 0.0 induration.

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R147 was admitted to the facility on 9/16/18. R147 was screened of r signs and symptoms of tuberculosis on 9/16/18. R147 had the first step Mantoux on 9/30/18, no time documented when given and read on 10/2/18, there was no documentation when read. Results of the step 1 Mantoux were negative and 0.0 induration. The second step Mantoux was not done.

Registered nurse (RN)-H was interviewed on 11/8/18, at 11:19 a.m., and confirmed the above findings. In addition, RN-H stated that the facility had a designated staff member to read employee Mantoux's but there was no one designated to read resident Mantoux's. RN-H agreed that R214 Mantoux was read outside of the time frame for reading of Mantoux and R147 did not have the two step Mantoux completed. At the time of survey, RN-H was the interim Infection Control officer for one month since the previous Infection Control Officer was no longer at the facility.

The facilities Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests policy was revised on 12/09. A qualified nurse or healthcare practitioner will interpret the TST forty-eight (48) to seventy-two (72) hours after administration. All test results must be read in millimeters (mm).

SUGGESTED METHOD OF CORRECTION:
The Director of nursing and/or designee could review and revise policies and procedures, train staff and monitor to assure Tuberculin Skin Tests (TST) are read, results documented with time given and read, and assure that residents are screened for tuberculosis (TB) using a symptom

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21426	Continued From page 61 screen, and by either a single step IGRA (Interferon Gamma Assay blood test) or a two-step TST and documented appropriately per State regulations. TIME PERIOD FOR CORRECTION: Twenty - One (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide activity engagement for 1 of 1 resident (R82) reviewed during the survey. Findings include: R82's Activity Assessment dated 8/5/18, indicated it was very important to her that she participate in her favorite activities. The	21435	Corrected.	12/18/18

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assessment identified activities of interest that included: religious services, group activities, music, books, newspapers, group activities and animals.

R82's quarterly minimum data set dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance for transfers, toileting and bed mobility. R82's care plan dated 8/4/18, indicated she was dependent on staff for activities. The care plan directed staff to escort R82 to activities and identified her preferences as nail care, special events, church and toddler time. The care plan indicated R82 enjoyed any kind of music.

R82's activity participation logs were reviewed and included the following activites:

8/7/18 to 8/31/18, R82 participated in 2 one to one activities, 2 group programs and one self directed activity.
9/1/18 to 9/30/18, R82 participated in 2 one to one activities, one group activity and one instance of watching television.
10/1/18 to 10/9, R82 had no documented activity attendance.
The activity attendance was requested through 11/8/18, but none provided after 10/9/18.
Review of the activity attendance lacked evidence R82 refused activity participation.

During observation on 11/4/18, from 1:30 p.m. to 4:30 p.m. R95 was lying in a reclining chair, leaning to her left side with her head resting on the armrest of the chair. R95 appeared to be asleep.

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On 11/5/18, at 8:21 a.m. R95 was asleep in a reclining chair in the television room outside the nurses station on the unit. R95 remained in the reclining chair until 9:26 a.m.

At 11:35 a.m. R82 was asleep in her wheel chair in the hallway outside the nurses station. At 1:29 p.m. she was asleep in a wheel chair in her room.

On 11/6/18, at 7:33 a.m. R95 was again lying in a blue reclining chair in the television room on the unit. R95 appeared to be asleep. She was leaning on her left side with her head lying on the arm rest of the chair. The chair was reclined all the way back. R95 still remained in the chair at 9:29 a.m.

At 1:09 p.m. R82 again was seated outside the nurses station alone.

On 11/7/18, at 6:50 a.m. a staff member directed R82 to remain seated in her chair. R82 replied, "I've ben sitting here ever since I got up." The staff member stated, "I know but I don't want you to fall."

On 11/7/18, at 6:24 a.m. R82 was seated in a wheel chair in the common area outside the nurses station. R82 stated, "I'll probably still be sitting just like this at supper time."

During interview on 11/6/18, at 1:11 p.m. registered nurse (RN)-M stated R82 did not really participate in activities unless it involved kids. She stated she usually just sits. RN-M stated R82 used to have a table in her room but she used it to stand so they got rid of it. She stated

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21435	Continued From page 64 R82 liked to comb her hair and do her makeup and stated the table used to have those things on it. During interview on 11/6/18, at 2:27 p.m. licensed practical nurse (LPN)-B stated R82 didn't really do anything. She stated if asked about activities R82 would say no and stated once in a while she would go. LPN-B stated, "I think they don't take her because she would be a one to one." LPN-B stated R82 used to have a brown box in her room that contained items she used to comb her hair and fix her face. On 11/7/18, at 1:55 p.m. RN-K stated R82 liked to sit and comb her hair and stated she would comb it all day. RN-K stated usually R82 had a table in front of her. RN-K stated she did not know if R82's niece had taken the table home. SUGGESTED METHOD FOR CORRECTION: The activity director or designee could develop systems of ensuring activity programming for residents. The Activity Director could educate all appropriate staff and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21435		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit	21610		12/18/18

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21610	Continued From page 65 only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to store refrigerated medications between 36 - 46 degrees Fahrenheit (F) in 1 of 5 medication refrigerators. Additionally, the facility failed to remove expired stock medications from medication storage on 4 of 9 medication carts, which had the potential to affect residents residing on the transitional care unit (TCU), first floor south, third floor north and second floor north west. Findings include: On 11/8/18 at 9:00 a.m., registered nurse (RN)-E verified the first south west medication refrigerator temperature log indicated the temperature was not kept within the allowable range (36 - 46 degrees F). Review of the log indicated the refrigerator temperature was less than 36 degrees F. 25 times in the last 26 days. Stored in the refrigerator were 17 vials Lantus insulin for R89, and 2 Levemir flex pens and 11 Novolog flex pens for R51, and 11 vials of influenza vaccine. RN-E indicated maintenance would be called to adjust the temperatures During medication storage review of the TCU 600 wing medication cart on 11/5/18, at 10:32 a.m. with licensed practical nurse (LPN)-A, the following medications were found to be expired: -Folic Acid 400 mcg 110 tablet bottle, one fourth full, expired 7/18.	21610	Corrected.	

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21610	Continued From page 66 -Vitamin D3 50,000 iu, 24 caplet bottle, 9 tabs in the bottle, expired 9/18. LPN-C indicated these medications were stock did not think any residents were currently receiving these medication. During mediation storage review of the TCU 500 wing medication cart on 11/5/18 at 10:55 a.m. with registered nurse (RN) - D, the following medications were found to be expired: -Vitamin E 400 iu 100 softgel, 3/4 full expired 8/18. -Optic-vits with lutein 36 tabs bottle, 1/2 full expired 6/18. -Fexofenadine hcl tablet 180 mg, 30 tab bottle 1/2 full, expired 10/18. -Magnesium oxide 500 mg, 100 tablet bottle, 3/4 full expired 10/18. -Aspirin 325 mg, 100 tablet bottle, 3/4 full, expired 1/18. -Calcium 600 mg +400 iu vitamin D, 60 tablet bottle, 3/4 full, expired 10/18. All medications were verified by RN-D, as being stock medications and did not think any residents were currently receiving these medication. During medication storage review of 3 north near medication cart on 11/8/18 at 8:44 a.m., with LPN-B, the following medications were found to be expired: -Calcium 600 mg, 150 tablet bottle, full bottle, expired 10/18 -Magnesium oxide 500 mg, 100 tablet bottle, 3/4 full expired 6/18 -Zinc sulfate 220 mg, 100 tablet bottle, 1/2 full, expired 9/18 -Vitamin D 400 iu, 100 softgel bottle, full bottle,	21610		

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21610	Continued From page 67	21610		

expired 8/18
-Vitamin D3-2000 iu, 100 softgel bottle 1/4 full, expired 5/18
-Naproxen 220 mg 100 tablet bottle, 1/4 full, expired 6/18
All medications were verified by LPN-B as being stock medications, and did not think any residents were currently receiving these medications.

During medication storage review of 2 west far north medication cart on 11/8/18, at 9:14 a.m. with LPN-C, the following medications were found to be expired:
-Magnesium oxide 500 mg, 100 tablets, 1/2 full, expired 10/18.
All medications were verified by LPN-C as being stock medications.

Review of facility's discarding and destroying medication policy dated 2012:
12. Expired medications will be disposed of per state or contract pharmacy guidelines.

Review of the facility's storage of medication policy dated 2007 indicated:
9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses; station or other secured location. Medication must be stored separately from food and must be labeled according.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could develop and implement policies and procedures related to staff keeping medication carts secure and who may have access to medication carts.

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21610	Continued From page 68 The DON or designee, could provide training for all nursing staff related to staff about the importance of securing the medication carts. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain an environment that was clean, free from odors and in good repair in rooms 132, 282, 390, 247, 338 and failed to assure wheel chairs were clean and free from debris for three residents (R31,R54, R103) who resided in the facility. Findings include: During observation on 11/7/18, at 2:08 p.m. it was noted that room 132 had a musty mildew odor. A wall air/heating unit in the room was running.	21695	Corrected.	12/18/18

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In room 282 a feeding pump stand base was soiled with a light brown dried on substance. The same substance was observed on the carpet. In room 247 there were gouges in the sheet rock near the room door. In room 390 there were many boxes and bags stacked in the room. In addition there was a foul odor detected in the room. In room 338 there were gouges in the sheetrock, and R103, R31, and R54 had soiled wheelchairs.

On 11/8/18, at 9:42 a.m. the maintenance director (MD), environmental services director (ESD), and community relations/assistant administrator toured with the surveyor to interview about the observations noted on 11/7/18. In room 132 the maintenance director (MD) stated the heating units in the rooms were checked for mold and mildew. The MD stated the facility had a meter to check the air quality coming out of the heating units. The MD stated he would check the room with the meter after the tour.

In room 282 the ESD stated the stand and carpet are the responsibility of housekeeping to keep clean. The ESD called a housekeeper to the room to begin cleaning the feeding tube pump stand and carpet. In room 247 the MD stated the rooms were checked regularly for repair and painting needs. The MD stated no work order had been completed for that room. The MD stated when repairs were needed the staff should have filled out a work order and the maintenance department would get them completed as soon as possible. The ESD was shown R103's, R31's, and R54's wheelchairs and asked if there was a system for cleaning the wheelchairs. The ESD stated a system was being

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21695	Continued From page 70 worked on, but she would get the housekeeper to clean the wheelchairs. Room 338 also had gouges in the wall. Again the MD stated he would do an inspection of all the rooms and make sure the walls were repaired and painted. In room 390 there was still a foul odor and the boxes and bags were cluttering the room. The ESD stated it was difficult to clean room 390 because the resident told the housekeepers to leave. The ESD stated she had not had a discussion with the social worker or interdisciplinary team to come up with a plan for cleaning room 390. At 11/8/18, at 11:23 a.m. the administrator stated the staff was expected to fill out a maintenance request on the computer when there were cleaning or maintenance needs in the building. The adminstrator added the staff were taught how to complete the maintenance requests during orientation. Review of the facility policy Work Orders, Maintenance dated 8/2014, indicated facility staff were responsible for completing a work order request and turning it into maintenance for completion. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance director, environmental service director, or designee could ensure a preventative maintenance schedule was developed and the staff were educated on the importance of informing maintenance and/or environmental services of cleaning or repairs that were needed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further	21695		

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21695	Continued From page 71 recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		12/18/18

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R175) reviewed for dignity concerns was provided privacy in public areas of the facility. In addition, failed to provide a dignified dining experience for 1 of 4 residents (R95) reviewed for dining.

Corrected.

Findings include:

R175's diagnoses included depression, schizophrenia and muscle weakness obtained from the quarterly Minimum Data Set (MDS) dated 10/5/18. In addition, the MDS indicated R175 required extensive assist of one to two staff for activities of daily living (ADL's) including getting dressed and personal hygiene. The MDS also indicated R175 had not rejected cares. R175's care plan dated 10/9/18, identified dependence on staff for assistance with all cares related to cognitive deficits and directed staff to "Assist with adjusting clothing/blanket if [R175] midriff is exposed."

On 11/4/18, at 5:23 p.m. R175 was observed sitting in a wheelchair at the dining room table with her shirt over her head. R175's bare breasts were hanging out of the bra exposed to other residents, staff and visitors. During the observation nursing assistant (NA)-G was sitting across from R175 watching television, but did not cover R175 until surveyor questioned her. During the observation there were nine residents in the

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small dining room including two male resident's right across the table from R175.

On 11/4/18, at 6:37 p.m. R175 was observed seated in her wheelchair by the nursing station. Her shirt was observed over her head and her bare breasts were exposed again. At this time NA-H approached R175 from the front then went behind her and wheeled her down the hallway with her breast exposed to the back nursing station which was approximately 200 meters. As NA-H parked R175 four other residents were observed in the area and looked at R175. NA-H then stated to NA-I "who put this on this woman. I brought her here so you can get her ready." At 6:40 p.m. NA-I approached R175 and adjusted the shirt over the head as he wheeled R175 to her room.

At 7:09 p.m. when asked about the observation NA-H stated he had noticed R175 was exposed and that was why he wheeled her out of the area to the unit. When asked if he should have covered her up NA-H stated he was not assigned to R175 and that was why he had brought her back to the unit for NA-I to put her to bed.

On 11/6/18, at 2:09 p.m. registered nurse (RN)-I stated he would expect the staff to redirect, divert and fix the problem as this was not dignified to leave R175 in that manner.

On 11/6/18, at 2:49 p.m. the director of nursing stated "first of all, residents belong to all staff here. The staff should have covered her and removed her from the area. That was not dignified of staff to do that."

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21800	Continued From page 74 Dignified dining experience: R95's significant change MDS dated 8/31/18, indicated she was severely cognitively impaired and required extensive assistance to eat. R95's care plan dated 10/1/18, identified a self care deficit and indicated she could eat some finger foods independently when staff handed them to her and directed staff to feed all other foods. Review of a facility Progress Note dated 11/5/18, indicated R95's intake had previously been excellent, however had been lower recently. As R95 was unable to communicate, unsure why intake was now 0-25%. During observation on 11/8/18, at 12:43 p.m. R95 was seated in the dining room with staff assisting her to eat mashed potatoes and gravy and pureed quiche. R95 was reaching for things on the table and nursing assistant (NA)- J was moving items out of her reach. At 12:45 p.m. NA-J assisted R95 to drink a small sip of juice. R95 continued to reach for the cup and NA-J kept placing the cup out of R95's reach. NA-J then used a spoon to mix all of R95's food together on her plate. R95 was still reaching for her juice and NA-J continued to move it out of her reach. NA-J fed R95 a spoon full of the mixed together food. When NA-J attempted to feed R95 a second spoonful, R95 turned her head away. At 12:48, NA-J moved R95 away from the table without offering her anymore food or fluids. During interview on 11/8/18, at 12:52 p.m. registered nurse (RN)-A observed the food mixture on R95's plate. RN-A stated it was "100% not ok to mix food together." RN-A further	21800		

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stated R95 should have been offered more fluids before leaving the table.

At 12:53 p.m. NA-J indicated she did not see a problem with mixing R95's food together and stated she mixed up all her own food when she ate. NA-J stated R95 was not able to tell her if she wanted all of her food mixed together. When asked about the fluids, NA-J responded, "I gave her some juice."

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) dignity are maintained. Audits could be completed, and results of these audits are reviewed by the quality assessment and performance improvement (QAPI) committee could ensure compliance.

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