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: X6MK
Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245386**
2. STATE VENDOR OR MEDICAID NO. (L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLAYTON REHABILITATION & HEALTHCARE CENTER**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **02/01/2017**
6. DATE OF SURVEY **1/16/2019** (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 **50** (L18)
13. Total Certified Beds **50** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Laura Ducharme, HFE NE II 1/23/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 1/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

CMS Certification Number (CCN): 245386

January 23, 2019

Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

Dear Administrator:

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

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

Effective January 16, 2019 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2019

Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386030

Dear Administrator:

On December 18, 2018, we informed you that the following enforcement remedies were being imposed:

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

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

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

On January 16, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 22, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 11, 2019. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 29, 2018, as of January 16, 2019.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 16, 2019.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter dated December 18, 2018:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2019. be rescinded as of January 16, 2019. (42 CFR 488.417 (b))

In our letter of December 18, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 16, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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,

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

cc: Licensing and Certification File

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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L5) **SLAYTON, MN** (L6) **56172**

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1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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6. DATE OF SURVEY **11/29/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
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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

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(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 01/14/2019 (L20)

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____ 2. Facility is not Eligible
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **01111** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
December 18, 2018

Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386030

Dear Administrator:

On November 29, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

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

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

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

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

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

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 29, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING ______ B. WING ______	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE CENTER	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 11/26/18 through 11/29/18 during a recertification survey. Slayton Rehabilitation and Healthcare Center was found to be in full compliance with these requirements.	E 000		
F 000	INITIAL COMMENTS From 11/26-11/29/2018, a standard survey was completed at your facility by the Minnesota Department of Health. Slayton Rehabilitation and Healthcare Center was found not 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.	F 000		
F 684 SS=G	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	F 684		1/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2018

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
	245386	A. BUILDING ______ B. WING ______	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE CENTER	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

(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 684	Continued From page 1 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 appropriate assessment and medical treatment for 1 of 2 residents (R12) diagnosed with clostridium difficile (C-diff). R12 experienced actual harm including severe weight loss, overall decline and development of pressure ulcers. The findings include: R12's admission record indicates the resident was admitted to the facility on 3/13/16, with diagnoses including: dementia, constipation, muscle weakness, osteoarthritis, and dementia related behaviors of resisting care. Review of a Brief Interview for Mental Statuts (BIMS) assessment dated 9/25/18, revealed a score of 7, indicating R12 had severe cognitive impairment. In addition, the 9/25/18 Minimum Data Set (MDS) assessment indicated R12 required extensive assistance with bed mobility, transferring, dressing, toileting, hygiene and locomotion. Further, the MDS indicated R12 did not ambulate, was frequently incontinent of bowel and bladder, and weighed 146 pounds at that time. Review of R12's medical record revealed she was transferred to the emergency room (ER) on 9/6/18, for a dramatic change in her mental status. At that time, R12 was diagnosed with a urinary tract infection (UTI) and prescribed	F 684	In adherence to ensure ongoing, appropriate assessments and medical treatment of residents, all nursing staff have been educated on C-Diff detection and precautions. R12 was retested, treated, and no longer has symptoms. Room was terminally cleaned. All lab cultures given to DNS or designee for review and follow-up. Weights will also be reviewed and any needed updates will be forwarded to the MD and dietary manger for potential interventions. Any resident who exhibits or displays signs and symptoms of infection will be isolated per policy. Weight-loss audits and lab results will be completed daily x 2 weeks, weekly x 2 weeks and monthly x 2 months by Director of Nursing or designee. Results will be forwarded to thee Executive Director and QAPI for review and recommendation. Director of Nursing Services will monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING ______ B. WING ______	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE CENTER	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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F 684	Continued From page 2 Rocephin (antibiotic) 2 grams (gm) intramuscularly (IM) daily x 4 days beginning upon her return to the facility on 9/7/18. The medical record further indicated R12 was sent back to the ER on 9/19/18, due to decreased food and fluid intake and lethargy. During that ER visit, R12 was diagnosed with another UTI and sent back to the facility with a new order for Bactim DS (antibiotic) 800 mg-160 mg one tablet daily x 14 days. On 9/27/18, a faxed communication to physician indicated R12 was having "explosive, slimy, yellow-green BM (bowel movement)". Progress notes indicate nursing staff requested an order to obtain a stool specimen for C-Diff (a bacterium that causes inflammation of the colon, known as colitis). Nursing staff asked the physician (MD)-F if they should withhold R12's prescribed Bactrim due to her loose stool and requested another UA (urinalysis) at that time. MD-F ordered a UA to be obtained by Foley catheter for sterility of the sample, and provided direction if R12 continued to not eat or drink within 24 hours, staff were to provide IV (intravenous) fluids. According to the medical record, there was no further communication to MD-F after 9/28/18, to indicate whether staff had notified MD-F of R12's continued loose stools. Review of R12's 9/28/18, C-Diff laboratory analysis confirmed the C Diff Toxin was detected in R12's stool sample obtained 9/27/18. MD-F's documented response on the lab report included: "ok here." Although nursing staff had documented the notation, there was no documented follow up to determine what MD-F meant by the documented "ok here" comment, nor was there any mention about any type of precautions having been implemented.	F 684		

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F 684	Continued From page 3 Review of the 2018 Micromedex, adverse effects of Rocephin and Bactrim DS indicated C-Diff colitis was a serious potential complication of their use. Monitoring for both medications was to have included watching for signs of antibiotic-associated diarrhea and other super-infections. Review of R12's BM records indicated R12 experienced numerous episodes of diarrhea from September 2018 through November 2018. R12's care plan dated 10/7/18, identified a goal to keep R12's weight above 135 pounds (lbs) and to keep her meal intake greater than 60% due to her appetite and weight decreasing. In addition, care plan goals included for R12 to be free of urinary tract infections (UTI), and to have an adequate bowel movement (BM) at least every three days. Interventions indicated staff were to assist R12 with: mobility to and from the bathroom, transfers on and off the toilet with the use of a mechanical stand lift, to help with incontinence care as needed, and were to monitor R12's bowel status daily. The care plan also indicated R12 frequently refused to get up and out of bed, and exhibited verbal and physical resistance with cares. Review of R12's Active Physician's Orders from 11/1-11/30/18, indicated R12 was on a regular diet, mechanical soft texture and took a nutritional supplement- 2 Cal, 90 cubic centimeters (cc) two times a day. Review of R12's documented weights revealed an 8/31/18 weight of 153 pounds (lbs). Immediately prior to her diagnosis of C-difficile on 9/18/18, R12's weight was identified as 146.4 lbs. R12's weight 10/24/18 was recorded as 138 lbs,	F 684		

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and her weight documented 11/27/18 was recorded as 135.2 lbs (a total of 11.6% severe weight loss within 3 months).

R12's record was reviewed and nursing progress notes indicated:
9/8/18 at 4:09 a.m., Staff documented R12 "...did have some loose BM this a.m. No other adverse reactions noted to antibiotic."
9/16/18 at 5:27 p.m., indicated R12 had refused to get up that morning, or eat and drink anything for breakfast. The note further indicated R12 had experienced a large loose incontinent bowel movement earlier that day, and had only taken bites at the dinner (mid day) meal. This note also indicated R12 had a superficial open area on her ischium.
9/17/18 at 11:48 a.m., R12's physician faxed directions to treat the superficial area on R12's ischium.
9/17/18 at 3:31 p.m., a progress note indicated R12 had been seen by a physician, with her daughter present, and was treated for an extensor tendon injury.
9/18/18 at 7:06 p.m., a progress note indicated R12 was more confused and teary. The note further indicated R12's oxygen (O2) levels had been measured and were low, so the nurse had applied oxygen and notified the physician.
9/19/18 at 11:13 a.m., the physician's assistant (PA) responded to the notification about R12's confusion and oxygen implementation. The PA gave orders for staff to continue with the use of oxygen as necessary to keep R12's O2 above 90%.
9/19/18 at 4:50 p.m., a progress note indicated R12 had refused her breakfast and medications. The resident had been found sleeping soundly and did not arouse with verbal stimulation. R12's

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family member (FM)-A was notified and FM-A requested an evaluation at the ER. At 7:45 p.m. on that same date, the ER nurse called to notify staff R12 was staying overnight for observation and IV antibiotic therapy.
9/20/18 at 11:47 p.m., the nurse documented R12 had refused her medication and supplements earlier that shift.
9/21/18, at 2:01 p.m., staff identified R12 only consumed 2 glasses of supplement that day and a glass of water.
9/21/18 at 5:43 p.m., the progress note indcated R12 continued to be on Bactrim for a UTI. The note indicated, "No adverse reaction to the medication noted." R12 "took fluids poorly with much encouragement. Will take supplements."
9/22/18 at 4:04 p.m. the progress note indicated R12 had been, "Incontinent with a large amount loose BM and urine."
9/23/18 at 10:18 a.m., R12 was resistive to taking in offered liquids and food, although she had consumed her supplement that morning. R12 declined to get up that day.
9/23/18 at 10:19 a.m., the progress note indicated staff were treating a small scabbed area on R12's L great toe, but that R12 had "No open areas on buttocks". The note continued to identify R12 was on Bactrim DS for 14 days to treat a UTI, with "No adverse reaction to the medication noted." At 1:45 p.m., staff documented R12 had a large loose BM...R12 continued to decline food but had accepted milk and a supplement. At 6:01 p.m., staff documented R12 had only been up 4 hours that day, refused food trays.
9/25/18 at 12:04 p.m., a progress note indicated R12 was experiencing indigestion and heartburn. An antacid was given with orders to notify the physician in 24 hours if the symptoms continued. At 12:18 p.m., nursing documented while

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attempting to give R12 her morning medications, she would not drink from the straw like she usually did. R12 was described as very pale and mouth breathing (labored breathing). Although R12 did respond verbally when asked if she had pain, she kept her eyes closed. "Resident gradually having a decline....Refused to eat breakfast, fluids encouraged but resident would not drink." R12's vital signs were identifed as within normal limits. The note indicated FM-A was at the facility and staff had informed her of R12's current condition indicating R12 was voiding adequate amounts but had "loose incontinent" BM. Later notes that same day, indicated R12 remained in bed and appeared to be sleeping, refused dinner and refused her supplements. There was no documentation to indicate staff had called R12's physician to inform her of R12's decreased appetite, loose stools, or overall decline in health.

Further review of R12's progress notes indicated on 9/26/18 at 7:23 a.m., staff documented FM-A would be contacting the physician about her mother's condition. The note indicated R12 continued to refuse supplements that day. A note from 7:48 a.m. that day indicated, FM-A had arrived at the facility and had requested Tylenol every 6 hours as needed be given. A fax was sent to MD-F requesting the medication. There was no indication the physician was informed of R12's continued loose stools. At 9:28 a.m., the progress notes indicated R12 was offered breakfast and staff attempted to give her fluids both of which R12 refused. The note also indicated staff explained the risk of dehydration to R12, to which she replied, "I don't care."

Continued review of R12's progress notes

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F 684	Continued From page 7 indicated: 9/26/18 at 5:52 p.m., R12 was noted as having 2 large loose BM's. 9/27/18 at 8:01 a.m. a progress note indicated staff held R12's Miralax due to multiple loose stools. At 10:02, staff documented they'd held R12's Bactrim antibiotic and faxed R12's medical doctor (MD)-F regarding her continued loose stools. At 10:05, staff documented R12 had experienced 2 large foul smelling yellow-green stools during the previous night of 9/26/18. The note indicated R12 was taking fluids poorly and refusing solids. Staff requested orders for a stool specimen to test for C-Diff. The specimen was sent to the local hospital for evaluation. R12's vital signs at that time were: T 93.7 F, HR 92, and RR 20. Her O2 was 93%, however her skin color was noted to be very pale. FM-A took over feeding R12 a small glass of Gatorade, a cup of broth and a few bites of yogurt. At 12:08 p.m., staff received physician orders to obtain a catheterized UA if needed, and directions that if R12 had not eaten over 24 hours, staff were to administer an IV (intravenous fluids). There was no mention any contact precautions were placed for R12 with suspected C-Diff infection at that time. On 9/28/18, staff received a fax of R12's C-Diff laboratory results from MD-F. "Results are negative." The progress note indicated R12 was had experienced addition loose incontinent stools that a.m. There was no indication staff clarified the results with MD-F to ensure accuracy. R12 continued to have loose stools, refusing meals with continued behaviors. R12's Bactrim was discontinued on 10/1/18, related to the urinalysis (UA) culture being negative for infection, at FM-A's discretion, with MD-F's approval.	F 684		

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Progress notes and bowel reports indicated R12 was noted to have continued loose stools from 10/1/18 through 10/3/18.

A progress note from 10/11/18 at 10:40 a.m., indicated a quarterly care conference had been held, and staff noted an ulcer to R12's L (left) great toe, R12's noted weight was identified as 146 lbs, but there was no mention of R12's continued loose stools, any preventative measures, or any other skin concerns at that time.

10/16/18 at 1:35 p.m., staff documented R12's weight was 135.6 lbs, "Which is down 10 lbs. in two weeks." Resident refused trays today at breakfast and lunch. Accepted 2 supplement drinks and 120 cc of milk with much encouragement. A registered dietician (RD) consult was made that day for weight loss.

10/19/18 the progress note included, "areas of concern to resident's coccyx (buttock)." The note indicated a fax was sent to MD-F for treatment orders. At that time, the resident's regular air mattress was exchanged for a pressure relieving air mattress, a pressure relieving cushion was to be placed in R12's wheelchair and recliner, and the resident was then placed on a repositioning schedule.
10/23/18 at 11:09, the progress note indicated R12's declining health was discussed with the IDT (interdisciplinary team). Family declined hospice, the resident continued to eat poorly and required a total body mechanical lift as she was too weak to use a stand-lift.
10/26/18 at 10:33 a.m., staff added a pressure ulcer care plan for two Stage II pressure areas to R12's coccyx.

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F 684	Continued From page 9 10/27/18 at 10:46 p.m., staff noted R12 having a new opened area in the fold of her right abdomen. 10/29/18 at 6:32 p.m., staff noted orders were received for pressure areas on R12's coccyx and L great toe. There was no indication the physician had been informed of R12's continued loose stools and poor appetite. MD-G visited R12 at the facility for assessment. There is no mention, MD-G assessed R12's coccyx ulcers, nor was notified of R12's continued loose stools or the laboratory result MD-F reviewed for C-Diff from 9/28/18. There is also no mention staff mentioned R12's continued decline and weight loss to MD-G. (14) 11/9/18, staff discussed hospice and palliative care with FM-A. FM-A declined, as she hoped R12 would improve. FM-A requested R12's supplement be increased to three times per day vs 2. Staff discussed "updating MD" with the FM-A. FM-A asked to read the nursing fax before staff submitted it to the MD. There was no mention if a fax had ever been sent and no physician communication documentation could be found in R12's chart to request the increase in the supplement to three times a day. (15) 11/13/18 at 11:59, 27 days later, the RD performed an assessment on R12. RD-A identified R12 as having pressure ulcers on her coccyx and decreased weight to 138 lbs. Her nutritional diagnosis was inadequate food and fluid intake related to possibly having advanced disease and age as evidenced by triggering for weight loss over the past 1-2 months. Staff were ordered to monitor R12's weight, labs, chewing and swallowing, skin issues and intakes (eating and drinking). Continue plan of care. There is no indication staff had informed RD-A of R12's	F 684		

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continued loose stools.
Between 11/14 and 11/29/18, staff noted R12 continued to have loose stools. There was no documentation to indicate staff had communicated with the physician about the resident's continued loose stools.

When interviewed on 11/27/18 at 4:05 p.m., the director of nursing (DON) stated the expectation was to keep residents infected with C-Diff in their room until they don't have loose stools. The DON added, "We should have put signs up and initiated contact precautions until the stool specimen results came back."

During a subsequent interview with the DON on 11/28/18 at 8:37 a.m., regarding the positive C difficile lab result from 9/27/18, the DON stated she'd been unsure what the result was but stated MD-F had said it was "ok" so she'd assumed it was negative and no precautions were put in place. The DON verified staff should have followed up with MD-F to clarify what "ok" meant.

On 11/28/18 at 8:45 a.m., an interview was conducted with the laboratory technician (LT)-D from the [outsourced] Laboratory. LT-D confirmed R12's lab test for C-difficile infection had been documented as positive on 9/28/18.

During interview with LT-E on 11/28 at 9:02 a.m., the local hospital LT who sent the specimen out for testing, reviewed the results provided from R12's C-Difficile culture. LT-E agreed R12's results would be considered abnormal, and confirmed R12 had tested positive for C-difficile infection on 9/28/18.

During interview with licensed practical nurse

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F 684	Continued From page 11 (LPN)-A on 11/28/18 at 10:21 a.m., LPN-A stated R12's loose stools occur "off and on". LPN-A further verified R12 had never had any precautions put in place to prevent potential transmission of the C-diff infection, that R12's intake was very poor and that R12 had not eaten well nor wanted to get out of bed to eat either. During interview on 11/28/18 at 10:21 a.m., FM-A revealed she was R12's primary contact and visited R12 almost every day. FM-A was not aware R12 had a positive C-Diff culture and confirmed there had never been any special precautions implemented. FM-A stated she wondered if the C-Diff was why her mother wasn't eating well and was losing weight. On 11/29/18 at 3:51 p.m., the dietary manager (DM)-A was interviewed. DM-A said she reviewed weights weekly and if there was a loss of 5% or greater, she would notify the RD (registered dietician) of the need for a consult. DM-A confirmed R12 had refused all foods for the past two days. Interview with RD-A on 11/29/18 at 3:52 p.m., revealed the DM-A would notify her of a resident's weight loss by email or text. The RD would then call the facility. The RD said she only visited the facility once a month, but could access the electronic medical record if needed. DM-A would give her a list of residents to assess. If residents were not on the list, she would not be aware she needed to assess them and relied on DM-A to update the list. RD-A verified her expectation was DM-A should identify residents needing assessment and make any appropriate referral. During an interview with registered nurse (RN)-B	F 684		

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F 684	Continued From page 12 on 11/29/18 at 4:04 p.m., regarding R12's declining health, RN-B stated multiple discussions had occurred with FM-A about seeking hospice services for R12 due to her declining health status. Attempts to interview R12's physician were unsuccessful as she was on a medical leave. Phone messages were left for the facility's medical director and physician covering for MD-F but no responses were received. Although requested, policies related to nutrition, weight loss, assessment, pressure ulcers, and notification to the provider were not provided for review.	F 684		
F 689 SS=G	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 ensure appropriate assessment, monitoring and implementation of interventions was provided for 1 of 1 resident (R27) reviewed who experienced frequent falls. This resulted in actual harm for R27 who sustained a fracture from a fall. Findings include:	F 689	It is the practice of Slayton Rehabilitation and Healthcare center to provide continued interventions to prevent falls of residents. Residents identified as high-risk for falls have been reviewed and their fall care plan interventions were updated as needed.	1/11/19

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F 689	Continued From page 13 R27 was admitted to the facility on 7/30/18, with diagnoses including: heart disease, hypothyroidism (abnormally low levels of thyroid hormone), depression, high blood pressure, chronic obstructive pulmonary disease (COPD), osteoarthritis (degenerative joint disease), muscle weakness, hypoxemia (low oxygen level), difficulty walking, disorientation, and urinary incontinence. During observation on 11/26/18 at 3:18 p.m., R27 was observed to be sitting on edge of her bed with her socks on and no shoes, with her wheelchair parked across the room. A sign next to her bed on the wall read "Do not transfer yourself, it is not safe". During observation on 11/27/18 at 10:40 a.m., R27 was sitting in recliner with her wheelchair parked across room. During observation on 11/27/18 at 1:10 p.m., R27 was sitting on edge of bed drinking water and watching her television. Her wheelchair was once more parked across room. During interview on 11/28/18 at 9:12 a.m., nursing assistant (NA)-D indicated she felt staff could not really educate R27 due to her cognitive status. Staff would remind her not to transfer without shoes on. She made no mention of any other interventions that were to have been implemented by staff after each fall. During observation and interview on 11/28/18 at 1:11 p.m., with R27 in her room revealed she was sitting on the edge of her bed. She had been waiting for someone to help her, but staff never	F 689	R27's fall interventions were reassessed. Interventions were implemented to ensure appropriate monitoring of resident to remain as free of accident hazards as is possible. Nursing staff were educated on fall risk policy and adding care plan interventions immediately. IDT team will review these interventions and adjust as needed. Audits will be completed daily x 2 weeks, weekly x 2 weeks and monthly x 2 months after incidents by Director of Nursing, Director of Clinical Education, or designee. Results will be forwarded to Executive Director and QAPI for review and recommendation. Director of Nursing Services will monitor.	

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SLAYTON REHABILITATION & HEALTHCARE CENTER	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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F 689	Continued From page 14 arrived, so she transferred herself into her bed from her wheelchair. R27 said "It makes them [staff] mad [when she self transfers] but she was tired. Her wheelchair was observed beside her bed at that time. During observation and interview on 11/28/18 at 1:14 p.m., with nursing assistant (NA)-G and R27 in R27's room, NA-G asked R27 if she put herself into bed. R27 stated she had. NA-G reminded R27 she was to wait for assistance. NA-G indicated R27 was a little confused at times and was not supposed to transfer herself. During interview on 11/29/18 at 10:59 a.m., NA-G indicated R27 was shaky at times and that was why she should not transfer herself. R27 knew she was not supposed to transfer herself and will tell staff she was to wait for assistance. NA-G was unaware of any further intervention to prevent falls other than assisting R27 with transfers, wearing gripper socks in bed and to check on her when staff would walk by her room. During interview on 11/29/18 at 11:37 a.m., registered nurse (RN)-B indicated the director of nursing (DON) would have been the one who would of identified interventions needed and updated the care plan. During interview on 11/29/18 at 11:42 a.m., the DON was asked about R27's falls. Fall interventions had not been updated on care plan, or implemented. The DON stated "It is what it is". Her expectation was the care plan would be updated timely and have new interventions following a fall. There would not always be an update to the care plan or a change of treatment plan after each time R27 fell. The new assistant	F 689		

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F 689	Continued From page 15 director of nursing (ADON) who was currently being trained would be in charge of updating the care plans after a fall from now on. During interview on 11/29/18 at 2:19 p.m., R27 stated she wears gripper socks at night because she has falls. R27 is sitting on edge of her bed and points to her bathroom and states she only has that far to go but has to wait for someone to help her. When asked about her falls she stated she had "black and blue marks" from falls. They [staff] get mad if I try to get up [by herself]. They [staff] want to be there so she does not fall. During interview on 11/29/18 at 4:16 p.m., RN-C indicated R27 can sit on edge of bed independently. She was known to rummage through items on her table. When in her wheelchair, she rummages through her closet, wheels herself around and visits other residents. R27 needed stand-by assist for transfers, wore gripper socks, and had a sign next to bed to remind her not to transfer without help. RN-C felt R27 was not as confused as when she first came. RN-C made no mention of any other interventions she was aware of, such as ensuring the wheelchair was beside R27's bed. During interview on 11/29/18 at 4:21 p.m., licensed practical nurse (LPN)- A felt R27 was much more alert than she was admitted. LPN-A did agree R27 had been more confused. LPN-A indicated facility staff monitored R27 by assisting her to toilet before and after each meal and activity, along with visual checks when they walk past her room. LPN-A made no mention of how often staff were to walk by R27's room, only that they were to look at R27 when walking by.	F 689		

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F 689	Continued From page 16 Review of R27's fall incident reports, care plan, and nursing progress notes indicated on: (1) 8/5/18 at 6:50 p.m., R27 was found on the floor in her room after staff noticed her call light was on. R27 reported shortly after staff had taken off her shoes and left the room, she needed to use the bathroom. She stated she walked backwards using her walker, opened the bathroom door, and slipped and fell onto the floor. R27's "walker and wheelchair were not near resident, no shoes on feet, only socks". R27 was found to be incontinent, and had ambulated without staff assistance. No injury was noted. Staff identified an intervention to educate R27 to use the call light before getting up, and to keep her walker within reach. R27 reported staff had taken her shoes off Review of the the care plan indicated on 8/24/18, 19 days after her fall, staff finally updated her care plan to include educating R27 to use the call light before getting up. There was no mention of the identified concern for keeping her walker within reach noted on the care plan. The physician was not notified until the next morning at 2:55 a.m. There is no indication staff asked the physician for potential intervention ideas to keep the resident safe from falls in the future. (2) 8/12/18 at 2:15 p.m., R27 was heard shouting from her room. She was found by staff lying on her left side on the floor. R27 was oriented only to person and place and sustained a bruise to her left buttock, left thigh, and had redness on the back of her head. R27 suffered increased confusion, was incontinent and was noted to have foul selling BM. Vital signs (blood pressure, heart rate, etc) with neurological (neuro) checks were initiated. An ice pack was applied to her left thigh and posterior head. R27's fall predisposing factors were confusion, incontinence, gait	F 689		

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F 689	Continued From page 17 imbalance, ambulating without staff assistance, and improper footwear as she was noted to be wearing only socks and no shoes. Staff identified new interventions of using gripper socks on R27 when in bed, toileting her prior to laying her down, and obtaining a urinary analysis (UA) to rule out a potential bladder infection. The care plan was not updated immediately regarding R27 wearing gripper socks. That had not occurred until 8/24/18. Toileting prior to laying down was also not immediately updated and revised until 11/5/18, 85 days after her fall. R27's physician was notified at 3:58 p.m. of the fall with head trauma and use of antiplatelet medication (Aspirin and Plavix). There was no indication staff included the physician for potential intervention ideas to keep the resident safe from falls in the future. (3) 9/15/18 at 3:30 p.m., R27 was heard calling out for help and found lying on her right side on the floor in her room. R27 sustained an abrasion and bruise to her right elbow with complaints of right shoulder pain. Vital signs were taken and neuro's were completed. Ice was applied to right elbow. R27 was agitated previously that day about a recent room change. R27 was only orientated to person at that time. Predisposing factors for her fall included clutter, confusion, dislike of her roommate, recent room change, self-transfer attempt, poor balance, and poor safety awareness. Staff moved R27 back to her old room, reminded and educated her on using her call light. Her call light was to be kept within reach, and the wheelchair was to be next to her bed with breaks on and her bedside table within reach. R27's care plan was not updated to include keeping the wheelchair with breaks on next to the bed and bedside table within reach. R27's physician was notified of the fall, but there	F 689		

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F 689	Continued From page 18 was no mention staff included the physician as part of the interdisciplinary team (IDT) for potential intervention ideas to keep the resident safe from falls in the future. (4) 10/13/18 at 6:40 a.m., R27 was found sitting on floor by her bed. R27 had indicated she leaned forward to pick up candy and her wheelchair slipped out from under her. She reported she had not hit her head. Nothing hurt except her buttocks. No injury was noted and R27 was able to move all extremities without pain. R27 was orientated to person, situation, and place. There is no mention the physician had been notified of the fall, or included in the IDT for potential intervention ideas to keep the resident safe from falls in the future. There were no new interventions placed on the care plan at that time. (5) 10/21/18 at 5:39 p.m., staff heard R27 yell for help. R27 was found next to her recliner in her room. She indicated she ambulated to get candy from her bedside table, that had been placed by her roommates side of the room instead of beside her bed as directed. R27 had not used a walker or wheelchair and had no shoes on. R27 slipped on the floor, hitting her left side on her roommates recliner. R27 was oriented to person and situation. Predisposing factors to the fall included confusion of the resident, improper footwear, ambulating without assistance, no shoes on, and no gripper socks on. Her wheelchair was noted as parked outside of her room at the time of the fall. The IDT team identified R27's gripper socks should be on, possibly keep wheelchair locked by bed, and to keep R27's candy in a jar on stand beside her bed. There was no mention of why the previous interventions of gripper socks and the wheelchair by her bed were not implemented by staff to prevent the fall. the IDT team had interviewed an	F 689		

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F 689	Continued From page 19 unidentified aide who stated she put R27 to bed with her shoes on. The only conclusion the IDT could reach was R27 must have removed her shoes herself. R27 subsequently complained of left rib pain and was sent to emergency room (ER) for evaluation by recommendation of the ER physician. She was admitted to hospital until her return on 10/25/18 for left rib fractures as a result of that fall. A nurses note on 10/24/18 identified R27's friend had visited her in the hospital. The friend noted R27 was not wearing her hearing aides at the hospital. there was no mention in the fall documentation if R27 had been transferred to the hospital with her hearing aides after her fall. There was no indication R27's physician was consulted upon R27's return, to keep her safe from further falls and injury. (6) 10/31/18 at 10:00 a.m., R27 was found in her bathroom on the floor. She had previously been in the dining room at 9:55 and told a staff member she was remaining there for church services. When asked about the fall, R27 stated she needed to use the bathroom before church started, so she returned to her room. Once in the bathroom, R27 stated she was holding onto the sink after she washed her hands, lost her balance, and fell onto her buttocks, knocking the garbage can over. No injuries were noted by staff at that time. R27 was oriented to person. Predisposing factors were determined by the IDT to be confusion, recent change in medications, gait imbalance, recent change in cognition, recent illness, improper footwear, and ambulating without assistance. Identified intervention of increase checks and toileting after meals and before activities. There is no mention why R27 was not wearing appropriate footwear, or why she wasn't asked to use the restroom when interviewed by staff 5 minutes prior to her fall.	F 689		

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F 689	Continued From page 20	F 689		

R27 was care planned in august to have frequent checks and be toileted after meals on 8/24/18. There was no mention why this had not been followed as directed. There is no mention the physician had been called or included in attempts to prevent falls.
(7) 11/24/18 at 2:40 p.m., R27 was found laying on the floor in front of roommates bed. R27 indicated she put her shoes on, got out of bed to use the bathroom independently and fell. She was noted to have a bruise to left elbow and left upper arm, and was unsure if she hit her head. R27 was oriented to person, situation, place, and time. She had felt sick to her stomach and vomited a small amount. Predisposing factors confused, recent change in medication, gait imbalance, ambulating without assistance. Identified interventions at that time were to continue to toilet before and after meals and activities, post a sign next to her bed to reminding R27 to call for assistance. R27 was aware she needs assistance with transfers and was re-educated. The care plan was not updated to reflect the posting of the sign by her bed to remind to R27 to call for assistance. The physician was not notified until the next day, on 11/25/18 at 10:00 a.m. There was no mention the physician was asked to assist the IDT to identify interventions to prevent R27's falls. There was also no mention neuro checks were performed, since R27 was unsure if she had hit her head and exhibited increased confusion.

R27's 8/8/18 admission Minimum Data Set (MDS) assessment, indicated R27 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. R27 required extensive assistance of one staff for locomotion, dressing and toileting. She required limited

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F 689	Continued From page 21 assistance of one staff for bed mobility, transfers, and ambulation. Her balance was not steady. As a result, R27 was only able to stabilize with human assistance. R27 had a range of motion (ROM) limitation on one side of her upper extremity. She had occasional bladder incontinence, was short of breath with exertion, and was known to have pain and required medication. R27 had falls prior to admission, used antidepressants, was on supplemental oxygen, and required occupational (OT) and physical therapy (PT). R27's 8/11/18, Care Area Assessment (CAA) indicated she had a history of falls prior to admission to facility and had fallen since her admission. R27 had multiple fall risk factors noted including daily antidepressant use, weakness, balance deficit, unsteady gait with forward trunk leaning, walking with a shuffled pattern, and experienced decreased walking endurance. She was diagnosed with confusion and was known to have periods of increased confusion. R27 suffered from shortness of breath with exertion, and had decreased safety awareness. R27 was alert and able to verbalize her needs and use the call light appropriately at that time. R27's following 10/26/18, Minimum Data Set (MDS) assessment indicated R27 had a new BIMS showing a markedly decreased score of 3, indicating her cognition had further deteriorated to severe cognitive impairment. She required extensive assist of one staff for transfers and ambulation, had scheduled pain medication, had a history of falls, and was currently in PT. There was no mention of the 7 identified falls since her admission, including the fall with fracture.	F 689		

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F 689	Continued From page 22 Review of the undated Fall and Fall Risk, Managing policy revealed staff were to identify appropriate interventions specific to resident's risks and causes to prevent falling and minimize complications. Staff were to monitor and document resident's response to those interventions and re-evaluate the situation and interventions if a resident continued to fall. Staff were to consult the attending physician to minimize serious consequences of falls and identify possible causes.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		1/11/19

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F 726	Continued From page 23 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide competency testing before floor orientation for 1 of 5 staff (nursing assistant NA- F). Findings include: NA-F's personnel file indicated a hire date of 9/27/18. The facility's hire information indicated upon hire, NA-F was to have had a skills completion check list for competencies completed and witnessed by the registered nurse (RN). These skills included handwashing, gloving, bed making, denture care, mouth care, shaving, transfer belt policy and proper use, toileting, ambulating residents with a cane or walker, placing residents in a side lying position, transferring residents by self or with another staff to a resident's bed or wheelchair, giving a partial bath, incontinence personal care, assistance with feeding, measuring and recording intake and output for diet and fluids, use of mechanical lifts, and catheter cares. In addition the Skills Completion Check List did not include any mention of isolation precautions, or appropriate whirlpool tub and shower cleaning and disinfection. NA-F's floor orientation checklist, to be performed in the presence of another NA and signed by the nurse after orientation lacked documented	F 726	Latest hires were taken back through the competencies and deemed competent. Competencies have now been added to staff orientation packets. Competency testing is completed annually, as determined by employees hire date, and as needed throughout the year. Random audits will be conducted by Director of Clinical Education, Director of Nursing Services or designee. Results will be forwarded to the Executive Director and QAPI for review and recommendations. Director of Nursing is responsible to monitor.	

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F 726	Continued From page 24 evidence NA-F was competent in providing female personal care with an indwelling catheter, cleaning of resident shavers, resident hand and nail cleaning, use of resident meal cards, feeding and marking intake and output for affected residents, transfers, the brushing of residents' teeth including denture care, the use of adaptive equipment, and isolation precautions. During interview on 11/28/18 at 1:57 p.m., the director of nursing (DON) was asked about staff competencies. The DON stated competency evaluations had been completed since the RN responsible for overseeing those had resigned a little over a month ago. The DON confirmed no competencies had been completed for NA-F upon hire. The DON verified staff were supposed to ensure competencies were evaluated prior to NAs working independently. Review of the facility's May 2018, Facility Assessment and Profile revealed all new hires were to be tested on competencies related to their job description and any special care or needs for the residents at the time of hire. Skills training was to be completed with all NAs upon hire and before staff were deemed to work independently.	F 726		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced	F 800		1/11/19

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F 800	Continued From page 25 by: Based on observation, interview and document review, the facility failed to implement a medically necessary diet for 1 of 1 resident (R20) with a known history of aspiration (food and fluid is inhaled into lungs). Findings include: R20's was admitted on 4/27/10, with diagnoses of bipolar (mood) disorder, dementia without behavioral disturbance, constipation, dysphagia, major depressive disorder, gastro-esophageal reflux diseases (GERD), other speech disturbances, and schizophrenia. Review of the 9/14/18, Minimum Data Set (MDS) assessment included a Brief Interview for Mental Status (BIMS) score of 9, indicating R20 suffered from moderate cognitive impairment. The MDS also indicated R20 required supervision and set-up with eating, had signs and symptoms of a swallowing disorder including as loss of liquids and solids from his mouth when eating or drinking, experienced coughing or choking during meals, and had difficulty chewing his food. During observation on 11/26/18 at 6:17 p.m., R20 was seated at the dining room table eating independently. R20 was observed to have a whole hamburger bun on his plate with ground sloppy-joe beef filling. During the observation, R20 experienced several episodes of coughing. He took drinks of his thickened liquid to help clear his throat. During observation on 11/27/18 at 12:32 p.m., R20 was seated at the dining room table eating beef stroganoff with ground beef, fiesta corn, a	F 800	The facility will implement a medically necessary diet for all residents of Slayton Rehabilitation and Healthcare Center. Speech therapist was consulted regarding R20's diet. Speech therapy order obtained. Nursing and dietary were communicated of mechanically-altered diet. The order is on the resident's care plan. Diet orders have been compared with the diet tickets and updated as needed. Resident care plans interventions have been updated to include therapy recommendations. Speech Therapy has been consulted and will notify both nursing and dietary of any therapeutic diet changes. Random audits will be conducted by the Director of Nursing Services, Dietary Manager or designee. Results will be forwarded to the Executive Director and QAPI for review and recommendations. Director of Nursing Services is responsible to monitor.	

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fruit cup, and thickened liquids. While R20 was eating his stroganoff, he was observed to experience several coughing episodes where his eyes watered and he had to blow his nose. R20 was observed to consume drinks of his liquids between bites. At 12:39 p.m., the director of nursing (DON) reminded R20 to slow down and take a drink stating, "Remember what therapy told you." An unidentified nursing assistant (NA) then came over and sat next to R20. R20 told the NA he had plenty of fluid but was having trouble eating. He pushed his plate away and stopped eating at that time. R20's eyes continued to water from coughing and he was noted to have only consumed 1/4 of his stroganoff and ate nothing else on his plate.

During observation on 11/28/18 at 8:18 a.m., R20 was seated in dining room eating hot cereal. R20 had 3 cups of honey-thickened liquids including milk, coffee, and cranberry juice. R20 was observed to have only 1 episode of coughing during the meal.

Review of R20's progress notes revealed on:

10/23/2018 at 1:29 p.m., staff documented R20 was having increase coughing at meal times. Staff discussed R20's coughing in the interdisciplinary team (IDT) meeting and received a physician's order to request a ST (speech therapy) to evaluate and treat related to R20's increased coughing with meals.

11/13/18 at 12:26 p.m., registered dietician (RD)-A documented R20's current diet was a Con-CHO (consistent carbohydrate), ground meat, and honey-thickened liquids.

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F 800	Continued From page 27 Review of the 10/25/18, dietary communication note, written by ST-B, indicated the kitchen was to start a diet of NDD2, ground meats, honey-thickened liquids and a trial of no breads during meals, with Con CHO diet. Review R20's current care plan indicated R20's ability to feed himself fluctuated from independence to the need for staff assist due to factors including dysphagia with the potential for aspiration, decreased hand coordination, messy eating with frequent spillage, and increased somnolence (sluggish behavior) requiring staff assist with tray set-up. R20's care plan also indicated an 11/6/18 swallowing study had been completed, indicating R20 would aspirate with thin liquids. The 11/6/18 swallowing study indicated R20 was to receive a mechanical soft diet with added moisture, and nectar thickened liquids. ST suggestions were for R20 to perform chin tucks and eat small amounts at a time for optimal and safe intake of food and fluid. However, these interventions were not identified on the care plan. Review of R20's 11/7/18, Speech Therapy Discharge note indicated an order a diet of NDD2, ground meat, honey-thickened liquids, no bread-like textures, and added moisture. During interview with dietary aide (DA) on 11/27/18 at 12:51 p.m., DA-A indicated a mechanical soft diet consisted of ground up meat. DA-A also said "Today's dinner dessert is apples and oranges. Residents who receive mechanical soft diets are given fruit cocktail as it is softer and smaller for them to eat." Interview on 11/28/18 at 9:04 a.m., with the	F 800		

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director of nursing (DON) indicated R20's coughing had increased recently. The DON said R20 was evaluated by ST on 10/25/18. The ST recommended new orders with no follow up at this time. Staff located in the dining room were to remind R20 to slow down when eating and ask him to clear his mouth. If R20 was identified by staff to have continued or increased problems swallowing in the next month, staff would refer him back to speech therapy (ST).

Interview on 11/28/18 at 10:35 a.m., with registered nurse (RN)-B indicated dietary was responsible for any dietary changes on the care plan, although anyone could make changes.

Interview on 11/28/18 at 10:37 a.m., with the DON indicated changes to the care plan were to be completed by RN-B. If there was a new dietary order, the dietary department would receive that information from nursing staff. The DON said R20 knew he could not have bread but would continue to request sandwiches. The DON was unaware R20 had been served his meal with a whole bun and was subsequently having coughing episodes.

Interview on 11/28/18 at 10:39 a.m., with dietary manager (DM)-A indicated R20's diet consisted of honey-thickened liquids, mechanically soft meats, and a Con-CHO. DM-A thought ST was doing a test with R20 related to breads. DM-A said the toast may have caused his coughing. DM-A said she was unaware R20 should not have bread, and was served a whole bun with his meal.

Interview on 11/28/18 at 1:07 p.m., DM-A indicated when a new order was received from nursing, it was posted on the shelf in the kitchen for staff to see. At that time, DM-A verified they'd

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F 800	Continued From page 29 received a copy of the above dietary order indicating R20 was to have had no breads during meals. Interview on 11/29/18 at 2:13 p.m., with the DON revealed ST-A would communicate with both nursing and dietary any changes in dietary orders. The DON stated the dietary order should have been placed on the nursing and NA care plans. Interview on 11/29/18 at 2:21 p.m., with NA-H indicated staff refer to the dietary card brought to the table when serving R20. NA-H said if she had concerns or questions she would ask other staff. NA-H was unaware ST-A had recommended no breads to prevent coughing. During a follow up interview on 11/29/18 at 3:14 p.m., the DON verified the nursing and NA care plans had not been revised to reflect R20's current dietary needs. The DON said there had been a breakdown in communication. Interview on 11/29/18 at 3:53 p.m., registered dietician (RD)-A indicated she was new to the facility and had only been there 3 times. She was not aware of any dietary changes for R20. Although requested, policies related to dietary orders were not provided.	F 800		
F 812 SS=D	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,	F 812		1/11/19

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F 812	Continued From page 30 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. (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 to ensure 2 of 6 dietary personnel (dietary manager (DM)-A and nursing assistant (NA)-A) followed appropriate infection control technique while preparing and served food during 1 of 1 meals observed. Findings include: During observation on 11/26/18 at 5:52 p.m., the dietary manager (DM-A) was observed picking up hamburger buns for the evening meal with her bare hands. DM-A reached into the bag containing buns with her bare hand. DM-A opened the bun, placed bun on a plate, grabbed the handle on the scoop, and dished up sloppy Joe mix onto the bun. DM-A then closed the bun with her bare hands, and proceeded to touch each serving handle as she scooped the rest of the meal items onto the plate. DM-A then handed the plate to a dietary aide to serve. DM-A walked away from serving line, and picked up additional plates out of the plate holder, touching them with	F 812	The facility nursing staff and dietary staff have been educated on the appropriate infection control techniques and the safe handling food policy. Education has been conducted on proper food handling practices. Audits will be completed daily x 2 weeks, weekly x 2 weeks and monthly x 2 months by the Dietary Manager, Director of Nursing Services, or designee. Results will be forwarded to the Executive Director and QAPI for review and recommendations. Dietary Manager is responsible to monitor.	

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her bare hands, and returned to the serving line. DM-A failed to wash or sanitize her hands prior to resuming to serve the evening meal. DM-A picked up another hamburger bun with her bare hands, opened it, and placed it onto a plate. When questioned about risk of cross-contamination and infection control, DM-A stated, "I guess I don't know how else I could do it". DM-A continued to pick up another hamburger bun with her bare hands for meal service once more. When asked if she could use the same process as she had for the french fries she served by utilizing tongs, DM-A obtained tongs and finished serving the evening meal.

During interview on 11/28/18 at 7:42 a.m., DM-A indicated she does not complete competencies for dietary staff. "They all have been here and should know what to do." DM-A indicated it was not a standard practice for staff to touch food with bare hands. She agreed she should have served food in an appropriate manner to prevent cross contamination.

During interview on 11/29/18 at 3:52 p.m., registered dietician (RD) indicated her expectation would be staff should not be touching food with their bare hands. All dietary staff were to follow Serve Safe guidelines. Tongs or gloves should have been used to retrieve the above mentioned buns from the bag. If staff were assisting a resident to eat, appropriate flatware or gloves should have been utilized while assisting a resident to eat.

Interview on 11/29/18 at 6:00 p.m., with the DM-A indicated she was not trained in Serve Safe. Only one unidentified dietary staff member had been certified in that course.

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Review of the undated Preventing Foodborne Illness-Food Handling policy indicated employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents.
R3's face sheet indicated he was admitted to the facility on 2/19/15, with diagnoses of Parkinson's disease, type 2 diabetes, and dementia.

R3's care plan dated 8/4/2013, indicated he required assistance of one with eating. R3 had a decline in manual dexterity (hand coordination) related to (r/t) his Parkinson disease, failure to initiate eating, drowsiness with intermittent dozing off during meals, or not opening his eyes.

Observations on 11/26/18, during the evening meal revealed at:
(1) 6:14 p.m., nursing assistant (NA)-A picked up R3's sloppy Joe with her bare hands, rather than using appropriate flatware, and proceeded to feed R3.
(2) 6:20 p.m., NA-A offered R3 another bite of his sandwich with her bare hands. NA-A continued to feed R3 french fries with her bare hands.
(3) 6:26 p.m., NA-A gave R3 another bite of french fries using her bare hands, then placed her hands in her lap, touching her scrub pants between each bite of food offered.
(4) 6:28 p.m., NA-A proceeded to wipe R3's nose with his clothing protector, using her bare hands. She then continued to assist R3 with eating his sloppy Joe. NA-A had not performed appropriate hand hygiene between touching R3's food and her scrub pants.

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F 812	Continued From page 33 During interview with on 11/26/18 at 6:45 p.m., with NA-A revealed staff normally do not wear gloves while feeding as long as they do not touch the residents mouth. During interview on 11/26/18 at 6:49 p.m., with DM-A indicated her expectation was if staff had performed appropriate hygiene during meals, it was ok to assist residents with finger food without gloves. During interview on 11/27/18 at 2:03 p.m., with the director of nursing (DON), it was her expectation staff wear gloves or use utensils when assisting residents with all foods. During interview on 11/28/18 at 2:35 p.m., with the administrator revealed it was her expectation staff staff wear gloves or use utensils when assisting a resident. Review of the undated Assistance with Meals policy made no mention staff were to use gloves or utensil use when assisting residents with eating.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		1/11/19

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F 880	Continued From page 34 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 35 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for surveillance of infections was maintained including tracking and trending of resident and staff illnesse; and failed to ensure infection control interventions were appropriately implemented by staff for disinfection of bathing equipment, and handling of soiled linens. These failures had the potential to affect all residents residing in the facility. Findings include: Review of the Infection Control Log tracking form for September, October, and November 2018 revealed: In September of 2018, R12 and R22 had urinary tract infection (UTI) and the organism was not tracked. In October of 2018, R11 and R234 had a UTI and the organism was not tracked.	F 880	Slayton Rehabilitation and Healthcare Center ensures a system for surveillance of infections maintained including tracking and trending of resident and staff illnesses, infection control interventions implementation and handling of soiled linens. All staff have been re-educated on the Laundry & Bedding, Soiled Policy. All staff have been re-educated on proper disinfecting of whirlpool and shower areas. Competencies are being completed on whirlpool disinfecting. These competencies are included in the onboarding process and will be completed yearly. Tracking and Trending completed by Director of Clinical Education. The results are forwarded to QAPI to determine if efforts to identify illnesses	

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F 880	Continued From page 36 In November of 2018, seven total residents had been documented as having UTI's. The facility failed to document the organism responsible for UTI for R11, R15, and R22. The form failed to mention if any trending for commonality existed between infections for R2, R11, R15, R20, R22, R27, and R234. During interview and document review on 11/28/18 at 1:57 p.m., the DON stated employee illness tracking and trending had not occured since the last entry 10/22/18. The DON said she had not had time to review or track staff illnesses since that date. The DON agreed employee illness needed to be tracked for the safety of residents. During interview with the DON on 11/29/18 at 4:01 p.m., regarding surveillance of the infection control program, the DON confirmed that she looked at the symptoms rather than the organism and verified would be difficult to analyze the data of the infections without knowing the causative organism. The DON said she had not had time to look at the data for November, and confirmed two of residents had chronic UTI's. The DON said the medical director had not been made aware of the large number of UTI's the facility had in the month of November. An infection prevention/control policy was requested and was not provided. During interview on 11/28/18 at 7:56 a.m., in the whirlpool tub and shower room with nursing assistant (NA)-C revealed she would disinfect the tub by spraying on Virex II 256 (quaternary cleaner and disinfectant), let it sit for 2 minutes, and rinse it off. She would use bleach for the tub	F 880	succeeded or not. Audits will be completed daily x 2 weeks, weekly x 2 weeks and monthly x 2 months by the Director of Nursing Services or designee. Results will be forwarded to Executive Director and QAPI for recommendations and review. Director of Nursing is responsible to monitor.	

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F 880	Continued From page 37 if there was a resident with any infection, but was uncertain how long to it would take for the bleach solution to disinfect the whirlpool tub jets. NA-C would use the Virex for the shower chair for residents with infections. The only bottle of disinfectant available in the locked cupboard in the bathing room was Virex. During interview in the tub room on 11/28/18 at 8:06 a.m., NA-D explained tub cleaning included using the built in spray nozzle on the whirlpool tub after switching it to disinfect. She used the chemical cleaner automated with the whirlpool tub. She would spray the whirlpool tub down and lift it sit for only 1 minute. Then use nozzle to spray out the disinfectant. For residents with infections you would add bleach and let the tub run for 20 minutes. For residents with infections they are the last baths of the day. For shower cleaning NA-D stated we use Virex II 256 spray down the whole chair with and leave it sit on for 1 minute, then rinse it off. During interview in the whirlpool tub room on 11/28/18 at 8:10 a.m., NA-B stated she used Virex II 256 spray for cleaning and disinfection of the whirlpool tub and shower chair. Her process was to spray the Virex II 256 on the walls of the whirlpool tub and shower chair, and let it sit 5-10 minutes before rinsing. If the resident is on precautions that bath is given last. Then put 1/2 - 1 cup of bleach in the tub and leave bleach in the tub for 5-10 minutes. The jets are not one when either the Virex II 256 spray or bleach is in the tub. During all staff interviews NA-B, NA-C, and NA-D indicated they were shown how to disinfect the whirlpool tub and shower chair by other nursing	F 880		

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F 880	Continued From page 38 assistants . They had not received any formal training on how to appropriately disinfect the whirlpool tub or the shower chair. Review of the posted instructions for whirlpool tub disinfection, located hanging on the wall advised staff to disinfect the whirlpool tub for resident with known infections. Staff were to fill the whirlpool tub with water, add 1/4 cup of bleach into water and run tub for 10- 15 minutes with jets on, submerge the chair, then disinfect per usual with tub disinfectant. Staff were to ensure to pull all drains apart and disinfect "per usual", connecting the sprayer to drain and run a disinfectant through. Staff were to bathe MRSA, shingles, VRE last each day. There was no mention of how staff were to appropriately disinfect for C-diff on the posted instructions. No directions were noted for the shower chair. Interview on 11/28/18 at 10:07 a.m., with NA-D bath sheet reviewed for some residents does not indicate if the resident takes a shower or a bath. NA-D indicated which residents normally take a whirlpool tub, shower or a bed bath. This listing is indicated on a resident roster form. Interview on 11/28/18 at 9:54 a.m., with the DON verified her expectation it that staff know how to clean the tub/shower and do it per manufactures guidelines for cleaning the tub and shower chair. Manufacturer's guidelines for Cen-Kleen IV disinfectant cleansers with the Rhapsody/Primo P200+ whirlpool tub note to disinfect the entire tub and scrub the tub using the disinfectant at the bottom of the bath tub. Spray into the surface overflow outlet, press the disinfectant button and place the disinfectant spray under the lid. Staff	F 880		

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	245386	A. BUILDING ______ B. WING ______	11/29/2018

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F 880	Continued From page 39 were to let the disinfectant take effect according to the recommendation label on the bottle. Recommended wait time was 10 minutes to achieve disinfection. Staff were to press the button for resident shower on the control panel and rinse the whirlpool tub and accessories. Review of the Manufacturer's instructions for Virex II 256 indicated for disinfection, surfaces must remain wet for 10 minutes. There was no mention the Virex II 256 was effective at killing the C-Diff bacteria. R234 was admitted on 4/16/2003 with diagnoses of multiple sclerosis (autoimmune disease in which immune system attacks cells in the brain and spinal cord) and dementia. Review of R234's medical record indicated Miralax 17 G (grams) and Docusate 100 mg was held on the morning of 11/25/18 and 11/26/18 for loose stools. During observation and interview on 11/26/18 at 5:46 p.m., of R234 in his room revealed he had to stay in his room per staff instructions. "I have to stay here and that's ok, I don't really feel good." There was not a sign on the door of the room that indicated R234 was on contact precautions. There was also not any contact precaution personal protective equipment (PPE) outside of the room. During interview on 11/26/18 at 6:03 p.m., with registered nurse (RN)-A regarding R234 indicated over the weekend 11/23/18-11/25/18, R234 was having loose stools, so staff decided to keep him in his room. She was not sure how many loose stools R234 had in the last two days. Staff	F 880		

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collected and sent off a stool sample to be cultured.

During interview on 11/26/18 at 2:42 p.m., NA-E stated, "we would know which residents are on precautions through report. [R234] is not on precautions at this time."

During observation on 11/26/18 at 2:42 p.m., NA-E entered R234's room without gloves or gown on.

During interview on 11/26/18 at 2:48 p.m., LPN-A stated R234 was not on contact precautions at that time related to C-diff.

On 11/27/18 at 9:50 a.m. the laboratory value for R234's test for C-diff had been returned and no C-diff was identified as detected.

During interview on 11/27/18 at 2:05 p.m., the DON stated the facility followed the Minnesota Department of Health (MDH) protocols for C-diff precautions. The procedure was to implement contact precautions once residents had 3 unformed stools in a 24 hour period or until residents had no loose stools for 72 hours. Residents were able to come out of their room if stool was contained. In R234's case, she waited to initiate contact precautions. She felt it was a miscommunication by staff. It was her expectation staff should have placed signage and initiated the contact precautions until the laboratory (lab) results came back conclusive for absence of the bacteria. Staff should have followed the CDI (clostridium difficile infection) prevention and control policy.

Review of the facility's 4/2018 Example CDI

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Prevention and Control policy, indicated all residents with suspected CDI or other diarrhea illnesses would be placed on contract precautions. Staff were to place a contact precaution sign on the resident's door, assure contact precaution supplies are outside and inside the resident room, and notify the infection prevention nurse. Gown and gloves were to be worn prior to entering resident's room and removed prior to exiting the room. Contact precautions were to be continued until the resident had no diarrhea for 72 hours.

During observation on 11/28/18 at 7:22 a.m. NA-C was observed to carry unbagged dirty linen to a soiled utility room with ungloved hands. NA-C was not observed to wash her hands after carrying the soiled linens, prior to entering the whirlpool tub room.

During interview on 11/28/18 at 7:24 a.m., NA-C was asked why she carried the linen without gloves. NA-C said she would normally bag soiled resident linens before transport and would also normally wash her hands after resident care or after touching dirty linens.

During interview on 11/28/18 at 9:54 a.m., the DON stated staff were to first bag soiled linens before carrying them out of a resident's room. The DON also said staff were suppose to wash their hands or use hand sanitizer after resident cares, and after handling dirty linen.

Review of the facility's undated Laundry and Bedding policy revealed contaminated laundry should be placed in a bag or container at the location where it was used. Further, the policy indicated anyone who handled soiled laundry was

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F 880	Continued From page 42 supposed to wear protective gloves and other appropriate protective equipment. R12 was admitted on 3/13/16, with diagnoses of dementia, constipation, muscle weakness, and osteoarthritis, and known to have dementia related behaviors of resisting cares. Review of R12's 9/25/18, Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) score was 7, indicating severe cognitive impairment. R12 required extensive assistance with bed mobility, transferring, dressing, toileting, hygiene, and locomotion. R12 did not ambulate and was frequently incontinent of both urine and bowel (BM). Review of R12's medical record revealed she was transferred to the emergency room (ER) on 9/6/18 for a dramatic change in her mental status. At that time, she received an order for Rocephin (antibiotic) 2 grams (gm) intramuscularly (IM) daily x 4 days, related to a diagnosis of UTI, beginning on her return to the facility on 9/7/18. On 9/19/18, R12 was sent back to the ER for decreased food and fluid intake and was found to be lethargic (sluggish). R12 was diagnosed with another UTI and sent back to facility with a new order for Bactim DS (antibiotic) 800 mg-160 mg one tablet daily x 14 days. On 9/27/18, a faxed communication to physician indicated R12 was having "explosive, slimy, yellow-green BM [bowel movement]". Nursing staff requested an order to obtain a stool specimen for C-Diff. Nursing staff asked the physician (MD)-F if they should withhold R12's prescribed Bactrim due to her loose stool and requested another UA at that time.	F 880		

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F 880	Continued From page 43 Review of R12's 9/28/18, C-Diff laboratory analysis indicated the C Diff Toxin was detected in her stool sample provided on 9/27/18. MD-F's response to that lab was documented as, "ok here" and noted by nursing staff. There was no mention of contact precautions having been implemented or staff following up with MD-F to identify what "ok here" meant. Review of R12's BM records indicated she had continued to have untreated, symptomatic diarrhea between September 2018 and November 2018. R12 averaged roughly 5 stools per day. R12's 10/7/18, care plan identified staff were to have helped R12 with incontinence care as needed and monitor her bowel status daily. There was no mention of any contact precautions on the care plan. Interview with director of nursing (DON) on 11/27/18 at 4:05 p.m., stated the expectation was to keep resident's who had C-Diff in their room until they don't have loose stools. The DON stated, "We should have put signs up and initiated contact precautions until the stool specimen results came back." Subsequent interview with DON 11/28/18 at 8:37 a.m., regarding the positive C difficile lab result on 9/27, indicated she didn't know what the result was but MD-F said it was "ok" so she'd assumed it was negative and no precautions were needed. The DON stated should have followed up with MD-F to clarify what "ok" meant. On 11/28/18 at 8:45 a.m., interview with laboratory technician (LT)-D from the [outsourced]	F 880		

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Laboratory, indicated lab staff tested R12's stool specimen for C-difficile toxin. LT-D confirmed R12's lab test was in fact positive for the C-difficile infection on 9/28/18.

Interview on 11/28 at 9:02 a.m., with LT-E from [local] hospital laboratory, who sent the specimen out for testing, reviewed the results. LT-E agreed with LT-D, R12's results would be considered an abnormal and R12 had tested positive for the C-difficile infection on 9/28/18.

Interview on 11/28/18 at 10:21 a.m., with licensed practical nurse (LPN)-A revealed R12's loose stools occurred "off and on". LPN-A confirmed R12 had never had any precautions put in place to prevent potential transmission of infection.

Attempts to interview R12's physician were unsuccessful as she was unavailable due to medical leave. Phone messages were left for the facility's medical director and physician covering for MD-F, but no callback was received.

R35 was admitted to the facility on 6/19/18 with diagnoses of anxiety, mood disorder and Alzheimer's disease, and was discharged to another facility on 9/6/18.

Review of R35's medical record revealed:
(1) A nursing note, dated 9/4/18, indicated R35 had two large, loose incontinent stools. The note also indicated a small amount of bloody mucous on rectum when cares were completed following the second loose stool.
(2) R35's Bowel Elimination Report indicated R35's loose stools began on 8/27/18 and continued through his discharge on 9/6/18. R35

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F 880	Continued From page 45 had at least one loose stool per day on average. R35 had 6 loose stools in a 24 hour period from 9/3/18 to 9/4/18. There was no mention of any further assessment of R35's loose stools or notification to the physican at any time. There was no mention of R35's looses stools on the care plan or interventions related to R35's loose stools. During interview with NA-C on 11/29/18 at 2:15 p.m., NA-C stated R35 had loose stools right before he left but she was unaware of how many or for how long; NA-C stated when a resident has loose stools, she charts it in the medical record and reports it to the nurse on duty. NA-C would have known if R35 was on contact precautions during daily shift report, or by the signage outside of the resident's room. NA-C does not recall R35 being under precautions during his stay and was not notified during any report. If stool looks like or smells like C-diff, she would report it to the nurse. Staff would initiate contact precautions with gloves and gowning, and utilize red garbage bags and yellow bags for linen, indicating a resident was on precautions. The facility's process was if a resident had an increased number of loose stools, nurse aide staff were to notify the nurse. Policies on C-diff and precautions are found in the Policy and Procedure book. The DON was good about notifying staff with policy changes and usually provided them with copies of new or updated policies. NA-C was aware of the "Example CDI Prevention and Control Policy". During an interview with licensed practical nurse (LPN)-A on 11/29/18 at 2:27 p.m., LPN-A could not recall R35 having loose stools during his stay. The facility procedure on loose stools depended upon the type of loose stools a resident was	F 880		

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having. LPN-A felt C-diff had a distinct look and smell. When asked about the facility protocol for suspected resident with C-diff, LPN-A stated the NA will report it to the nurse, the resident would be kept in their room, and an order would be requested for a stool sample from the resident's physician. The nurse would notify the family, and further treatment depended upon the results of the stool sample test. Precautions would not be placed unless a lab result confirmed a C-diff infection. LPN-A If positive, a sign would be put up and a personal protective equipment (PPE) cart would be placed outside of the resident's room. When asked if there was a facility policy on loose stools or C-diff, LPN-A stated she has seen one but was unsure what it entailed. When shown the "Example CDI Prevention and Control Policy," LPN-A stated she was not aware of that policy. Following review of the policy, LPN-A stated depending on number of stool and if there is no known reason for the loose stools, she would contact provider to get order to culture the stool. LPN-A also stated she would not wait for a confirmed lab result before putting precautions into place. LPN-A confirmed she would have contacted the provider and put a resident on precautions if they had 11 days of loose stools.

During an interview with LPN-B on 11/29/18 at 2:46 p.m., LPN-B confirmed she provided care to R35 and was aware of his loose stools. R35 went to the hospital and returned with loose stools. LPN-B could not recall if R35's loose stools were a continued concern, or if they lasted only one day. The NA would report residents with loose stools to the nurse. LPN-B would review the residents medications, when they had their last bowel movement and would determine what to do next. If a resident had 3 loose stools in a 24 hour

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period, she would place them on contact isolation, make sure staff was aware, remind them to use good hygiene, and notify the provider for further evaluation.

During interview on 11/29/18 at 2:55 p.m., with the director of nursing (DON) and the administrator revealed the DON was aware of R35 having loose stools. R35 left the facility and came back with loose stools. R35 returned to the facility on new medication. DON confirmed no infection prevention precautions were implemented for R35. The DON expected when a resident had loose stools, the nurse would look at current medication for potential adverse effects, and notify the provider if indicated. If a resident were to have 3 of more loose stools, the nurse should implement contact precautions and notify the provider to see if a stool culture needed to be obtained. The DON verified the "Example CDI Prevention and Control Policy," indicated precautions should have been placed when a resident had 3 or more loose stools in a 24 hour period.

Review of R35's medication regimen at that time when the loose stools occurred, indicated no mention of R35's loose stools being related to medication side effects.

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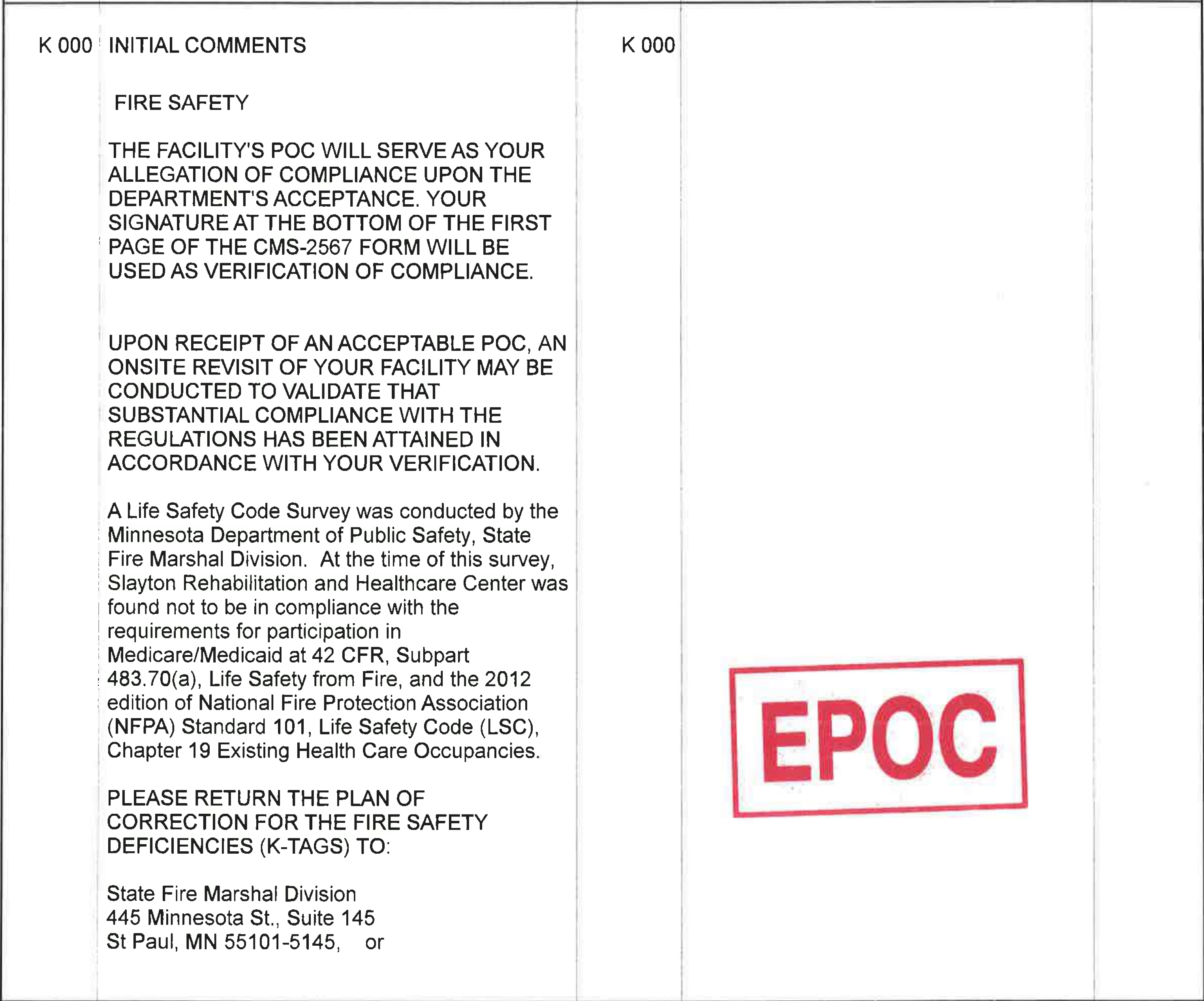

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Slayton Rehabilitation and Healthcare Center was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2018

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Slayton Rehabilitation and Healthcare Center was constructed as follows: The original building was constructed in 1965, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 35 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric	K 511		1/11/19

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

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SLAYTON REHABILITATION & HEALTHCARE CENTER	**2957 REDWOOD AVENUE SOUTH** **SLAYTON, MN 56172**

(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
K 511	Continued From page 2 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2. This deficient practice could effect 35 of the 35 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 11/28/18, items were observed directly in front of the electrical panel access doors in the Valve Room. This deficient practice was verified by the Facility Maintenance Director.	K 511	The Facility Maintenance Director (FMD), upon notification, during survey, immediately relocated the items to a different location. FMD will perform a monthly inspection of all electrical panels throughout the building and take the proper actions needed to maintain the three-foot clearance. FMD will create an automatic reoccurring monthly checklist in Building Engines program to prevent further incident. Results forwarded to QAPI for review. FMD will monitor.	