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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YIOF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00448

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245252**

2.STATE VENDOR OR MEDICAID NO.
(L2) **591605000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THIEF RIVER CARE CENTER**
(L4) **2001 EASTWOOD DRIVE**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

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) **11/01/2006**

6. DATE OF SURVEY **12/05/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
04/30

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

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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):
A post certification revisit was completed on October 31, 2018. This agency continues to be non-compliant.

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE - NE II 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/07/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/29/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 7, 2019

CMS Certification Number (CCN): 245252

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Dear Administrator:

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

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

Effective November 16, 2018 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
January 7, 2019

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: Project Number S5252028

Dear Administrator:

On November 16, 2018, we informed you that this department would be imposing enforcement remedies.

On December 5, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on October 31, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 16, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 16, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- The Category 1 remedy of state monitoring effective September 3, 2018, 2018 is discontinued as of November 16, 2018.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective November 18, 2018 be rescinded effective November 16, 2018.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new Medicare admissions, effective Novemer 18, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 18, 2018, is to be rescinded.

In our letter of November 16, 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 18, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 16, 2018 the original triggering remedy, denial of payment for

new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YIOF

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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) **11/01/2006**

6. DATE OF SURVEY **10/31/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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):
A post certification revisit was completed on October 31, 2018. This agency continues to be non-compliant.

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE - NE II 11/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/04/2019 (L20)

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

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____ 2. Facility is not Eligible (L21)

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
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24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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03001
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30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/29/2018
(L33)

DETERMINATION APPROVAL

Electronically delivered

November 16, 2018

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: Project Number S5252028

Dear Administrator:

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

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

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective November 18, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter from September 18, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on August 31, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 22, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 31, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2018. Based on our visit, we determined that your facility had corrected the deficiencies issued pursuant to our standard survey, completed on August 31, 2018.

However, at the time of this revisit, we identified the following new deficiencies:

F0697 -- S/S: G -- 483.25(k) -- Pain Management
F0760 -- S/S: G -- 483.45(f)(2) -- Residents Are Free Of Significant Med Errors

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

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

- Discretionary Denial of payment for new Medicare and Medicaid admissions effective November 18, 2018 will remain in effect. (42 CFR 488.417 (b))

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

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of September 18, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2018.

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	R 10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	**2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701**

(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 An onsite revisit was conducted on October 29-31, 2018, to determine compliance with CMS Appendix Z Emergency Preparedness Requirements cited on August 31, 2018. The facility is now in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post-certification revisit was completed on October 29-31, 2018 to determine the status of Federal deficiencies issued during a recertification survey exited on 8/31/18. The facility was found to have corrected all deficiencies issued. However, additional deficiencies were identified. As a result, the facility has not achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The findings are delineated in this document. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 1	F 697		

consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure pain management was provided for 1 of 1 resident (R50) who was identified has having pain. In addition, the facility failed to ensure that pain medication was available for R50's scheduled administration times, which resulted in 9 doses being missed.

Findings include:

R50's quarterly minimum data set (MDS) dated 7/31/18, indicated that R50 had intact cognition, experienced frequent pain that made it hard to sleep, limited day to day activities and required scheduled and as needed (PRN) medication. R50 rated pain 7 out of 10. Diagnoses included intervertebral disc degeneration, lumbar region, pain, unspecified, generalized anxiety disorder and major depressive disorder.

R50's pain care area assessment (CAA) dated 2/13/18, indicated pain interview done and resident stated he always had chronic pain in his back which he rated the worst pain in the lookback period was 7/10. He stated it does keep him from sleeping at night and it also makes it difficult to get out of bed and move around. Resident had Methadone 10 milligrams (mg) three times per day (TID) and Tylenol PRN which he used in the lookback period almost daily.

R50's general nursing observation started on 7/31/18 and completed on 8/1/18, indicated pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	R 10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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F 697	Continued From page 2	F 697		

interview done at that time and resident stated he always had chronic pain in his back. He rated the worst pain in the last week to be a 7/10. He stated it does keep him from sleeping at night and it also makes it difficult to get out of bed and move around. Resident does have Methadone 5 mg (TID), Biofreeze ointment and Tylenol PRN. He had Tylenol three times in the lookback period. He stated that he had pain over the past 5 days and stated that he frequently had pain in his back that measures a 7/10 at its worst, does affect his sleep, but not usually his activities. He said the pain medications help.

R50's care plan provided on 10/30/18, indicated R50 had chronic pain related to disc degeneration, lumbar region. Goal: resident will remain comfortable daily from pain. Approaches included administer analgesics per medical doctor (MD) orders; observe signs and symptoms of pain (grimacing, moaning, guarding) report to MD as needed; use pain scale 0-10 to determine pain level and effectiveness of medication.

Physician orders dated 10/30/18, indicated the following medications for pain control:
Methadone HCL 5 (mg) by mouth (TID) at 8 a.m., 2 p.m., and 8 p.m.
Acetaminophen extended release 650 mg - 1 tablet two times per day (BID) at 6 a.m. and 8 p.m.
Acetaminophen 650 mg every four hours PRN

Sanford Telephone Encounter dated 10/27/18, at 9:51 a.m. indicated nurse (from nursing home) stated she needs a refill of R50's Methadone. Stated she contacted MD-2, the on-call provider for the nursing home this weekend and he was not willing to write a prescription for his

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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Methadone. Advised R50 be evaluated in ER. Nurse stated she does not have a way to get R50 there.

Progress note written on 10/27/18, at 11:06 p.m. indicated as this nurse was coming on to shift at 6:30 a.m. it was passed on in report that resident was out of his scheduled methadone. Treatment nurse called the pharmacy, pharmacy stated they did not have a current prescription for the medication. Treatment nurse then called on-call MD-2 stated he could not help due to resident not being his patient. MD-1 (resident's MD) was unavailable for the weekend. MD-2 stated the resident would have to go to the emergency room (ER)/urgent care to receive medication. Resident refused. Nothing can be done until Monday.

On 10/29/18, at 4:10 p.m. licensed practical nurse (LPN)-A verified in the electronic medication administration record (E-Mar) the R50 had an order for Methadone 5mg TID and has not had scheduled Methadone since 2 p.m. dose on 10/26/18 (Friday). He has missed 9 doses total up to this time.
- At 4:12 p.m. R50 stated he was not good. They ran out of my pain medication and I have not slept for 48 hours straight. I have PTSD (post traumatic stress disorder) from the Vietnam War. I could not do my physical therapy because of the pain. Staff told me I could go to the emergency room/urgent care on Saturday, I did not go because they said they were working on getting my medication. I went and saw MD-1 at 9:30 a.m. today and he told me that he had not been notified by either the facility or the pharmacy that a new prescription was needed in order to refill Methadone. This also happened 2-3 months ago with my Ativan.

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- At 4:30 p.m. registered nurse (RN)-A stating she was under the understanding that the pharmacy and the nursing facility had been trying to contact MD-1 to get a new prescription written. They had taken R50 to see MD-1 this morning and it took until now to get the Methadone for the patient. RN-A stated R50 had been offered acetaminophen over the weekend. RN-A was not aware of any cold turkey (abruptly stopping medication) concerns regarding Methadone and staff were not monitoring for any of these concerns other than pain.
- At 4:45 p.m. LPN-A stated that the label from the medication card should be pulled and faxed to the pharmacy when there are 7 days left of the medication.
- At 4:45 p.m. Interim director of nursing (DON) stated she was not aware of any cold turkey concerns with abruptly stopping Methadone.
- At 4:55 p.m. R50 stated that staff did not make it clear to him that if he choose not to go to ER that he would not have Methadone available until Monday. He stated that staff assured him they were working on getting the medication filled.

On 10/30/18, at 8:09 a.m. DON stated that R50 is on the lowest dose of Methadone and he would let staff know if her were experiencing any withdrawal symptoms. DON could not provide any documentation that withdrawal symptoms were communicated to staff or R50.
- At 8:30 a.m. telephone interview with pharmacist from Thrifty White stated that he originally received a request from the nursing home to re-fill R50's Methadone on 10/18/18. Pharmacist stated that a fax was sent to the prescribing MD on 10/18/18, 10/26/18, & 10/29/18. Pharmacist stated he would be very concerned with withdrawal symptoms when a

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F 697	Continued From page 5	F 697		

person abruptly stops taking Methadone - these symptoms can be very serious and harmful to the person.
- At 9:05 a.m. R50 stated he had lower back pain and the Methadone helps with pain. He stated he didn't think he was "going to make it" over the weekend as the pain was so bad. I did not sleep Saturday and Sunday night for 48 hours straight. Staff kept telling me they were calling about getting his Methadone. They gave me Tylenol but that didn't help. They did not try to get me anything else for the pain and I asked many, many times and they said they couldn't get anything. What if I was dying, do I just die in pain? It made me feel sad and angry. I asked for an extra Ativan (anti anxiety medication) to help me sleep and they said they did not have an order to do that. They did not tell me that if I did not go to ER that I would not have Methadone until Monday. The did not explain any withdrawal symptoms but I think that probably is what a lot of this was. R50 stated he received two doses of Methadone yesterday and was able to sleep last night. He asked for his third dose at 3 a.m. today and was told he could not have it until 7 a.m. R50 stated he asked for his Methadone at 7:30 a.m. today but did not get it until 9 a.m. R50 rated his pain at a 7/10.
- At 9:25 a.m. LPN-B confirmed R50 received his Methadone at 8:47 a.m. and that she did not ask him to rate his pain at that. LPN-B stated we only rate pain when giving PRN medications.

Fax confirmation of nursing home re-order, received on 10/30/18, confirmed that Methadone refill for R50 was sent to pharmacy on 10/18/18.

Reiview of E-Mar indicated that R50 received acetaminophen 650mg as follows:

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F 697	Continued From page 6 - 10/27/18 at 1:22 p.m. for pain due to being out of Methadone - 10/27/18 at 5:22 p.m. for pain 7/10 - 10/28/18 at 12:56 a.m. for pain 7/10 affecting sleep - 10/28/18 at 8:32 a.m. for pain 5/10 - 10/29/18 at 12 midnight for pain 7/10 affecting sleep Physician's Progress note dated 10/29/18, indicated patient here for follow-up on chronic pain - back pain. Has been on Methadone for the last few months. Patient has been out of his Methadone and requested medication be restarted. Chronic pain, discussed options of tapering and discontinuing Methadone. Patient reports significant distress on any attempted taper. Pros and cons discussed and Methadone refilled for the patient. Appointment Transfer Sheet dated 10/30/18, with pain management MD-3 indicated increase pain without Methadone, could not function, sleep. Will resume Methadone, narcotic contract. Ordered Methadone 5mg TID and Tramadol 50 mg one tablet every 12 hours PRN for breakthrough pain. Message was left with MD-B's office on 10/30/18, at 8:45 a.m. Progress notes for R50 reviewed from 10/18/18 to present were absent of any notations (except above on 10/27/18) regarding R50 being without Methadone and what the facility did to rectify the situation. No indication that the facility made a request for additional medications that could have been helpful during the time R50 was without methadone or that R50 was educated on	F 697		

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withdrawal symtpoms that could occur and that he should report to staff.

Review of Medication Policy reviewed/amended 1/2016, directed the night nurse go through the medication carts and reorder as needed for Narcotics. This is scheduled every Sunday and Thursday.

Review of undated Pain Management Policy indicated:
- residents receiving pain management interventions will be monitored for pain levels on a scheduled basis, and/or PRN, using the appropriate scale.
- any residents routinely receiving a scheduled or PRN analgesic will be reassessed for appropriateness and effectiveness at periodic intervals. Potential adverse consequences associated with medications will be monitored and addressed.
- the physician will be notified when pain persists or reoccurs despite treatment or if suspected adverse consequences are noted.

According to http://methadoneclinic.com quitting methadone cold turkey (abruptly) that there will be intense withdrawal symptoms. These range from mild to severe:
Mild symptoms include sensitivity to light, runny nose, fever, chills, sweating, increased pain sensitivity, jitteriness or tremors, restlessness, lethargy, agitation or nervousness.
Severe symptoms include suicidal thoughts or actions, hyperventilation, severe anxiety and depression, insomnia lasting as long as three weeks, severe pain in the abdomen, joints and legs, visual, auditory and olfactory hallucinations, irregular heartbeat and blood pressure, severe

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F 697	Continued From page 8 itching, panic, paranoid delusions and anorexia. Stopping methadone completely suddenly can cause permanent mental disability, heart attack, seizures and sometimes death. Quitting cold turkey is very dangerous because it all but guarantees that the user will experience most if not all of the withdrawal side effects to the extreme. There is evidence of patients going clinically insane after suddenly stopping methadone and many of the withdrawal side effects are considered permanent damage. After completion of the survey on 11/1/18, at 1:15 p.m. MD-B returned phone call. MD-B stated absolutely this resident could have experienced withdrawal symptoms by not being provided his ordered methadone for 9 doses. MD-B also stated that his office had not been contacted by either the nursing home facility or the pharmacy requesting a re-fill of R50's methadone in the past 17 days. MD-B stated that his personal policy for re-filling medications is within 24-48 hours of being contacted. MD-B stated this was an unfortunate incident that should not have happened to R50.	F 697		
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest	F 742		

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practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to ensure that pain management was provided for 1 of 1 residents (R50) who was identified has having pain. In addition, the facility failed to ensure that pain medication was available for R50's scheduled administration times, which resulted in 9 doses being missed. This resulted in causing psychological harm to R50.

Findings include:

R50's quarterly minimum data set (MDS) dated 7/31/18, indicated that R50 had intact cognition, experienced frequent pain that made it hard to sleep, limited day to day activities and required scheduled and as needed (PRN) medication. R50 rated pain 7 out of 10. Diagnoses included intervertebral disc degeneration, lumbar region, pain, unspecified, generalized anxiety disorder and major depressive disorder.

R50's pain care area assessment (CAA) dated 2/13/18, indicated pain interview done and resident stated he always had chronic pain in his back which he rated the worst pain in the lookback period was 7/10. He stated it does keep him from sleeping at night and it also makes it difficult to get out of bed and move around. Resident had Methadone 10 milligrams (mg) three times per day (TID) and Tylenol PRN which he used in the lookback period almost daily.

R50's general nursing observation started on 7/31/18 and completed on 8/1/18, indicated pain interview done at that time and resident stated he

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always had chronic pain in his back. He rated the worst pain in the last week to be a 7/10. He stated it does keep him from sleeping at night and it also makes it difficult to get out of bed and move around. Resident does have Methadone 5 mg (TID), Biofreeze ointment and Tylenol PRN. He had Tylenol three times in the lookback period. He stated that he had pain over the past 5 days and stated that he frequently had pain in his back that measures a 7/10 at its worst, does affect his sleep, but not usually his activities. He said the pain medications help.

R50's care plan provided on 10/30/18, indicated R50 had chronic pain related to disc degeneration, lumbar region. Goal: resident will remain comfortable daily from pain. Approaches included administer analgesics per medical doctor (MD) orders; observe signs and symptoms of pain (grimacing, moaning, guarding) report to MD as needed; use pain scale 0-10 to determine pain level and effectiveness of medication.

Physician orders dated 10/30/18, indicated the following medications for pain control:
Methadone HCL 5 (mg) by mouth (TID) at 8 a.m., 2 p.m., and 8 p.m.
Acetaminophen extended release 650 mg - 1 tablet two times per day (BID) at 6 a.m. and 8 p.m.
Acetaminophen 650 mg every four hours PRN

Sanford Telephone Encounter dated 10/27/18, at 9:51 a.m. indicated nurse (from nursing home) stated she needs a refill of R50's Methadone. Stated she contacted MD-2, the on-call provider for the nursing home this weekend and he was not willing to write a prescription for his Methadone. Advised R50 be evaluated in ER.

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Nurse stated she does not have a way to get R50 there.

Progress note written on 10/27/18, at 11:06 p.m. indicated as this nurse was coming on to shift at 6:30 a.m. it was passed on in report that resident was out of his scheduled methadone. Treatment nurse called the pharmacy, pharmacy stated they did not have a current prescription for the medication. Treatment nurse then called on-call MD-2 stated he could not help due to resident not being his patient. MD-1 (resident's MD) was unavailable for the weekend. MD-2 stated the resident would have to go to the emergency room (ER)/urgent care to receive medication. Resident refused. Nothing can be done until Monday.

On 10/29/18, at 4:10 p.m. licensed practical nurse (LPN)-A verified in the electronic medication administration record (E-Mar) the R50 had an order for Methadone 5mg TID and has not had scheduled Methadone since 2 p.m. dose on 10/26/18 (Friday). He has missed 9 doses total up to this time.
- At 4:12 p.m. R50 stated he was not good. They ran out of my pain medication and I have not slept for 48 hours straight. I have PTSD (post traumatic stress disorder) from the Vietnam War. I could not do my physical therapy because of the pain. Staff told me I could go to the emergency room/urgent care on Saturday, I did not go because they said they were working on getting my medication. I went and saw MD-1 at 9:30 a.m. today and he told me that he had not been notified by either the facility or the pharmacy that a new prescription was needed in order to refill Methadone. This also happened 2-3 months ago with my Ativan.
- At 4:30 p.m. registered nurse (RN)-A stating she

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was under the understanding that the pharmacy and the nursing facility had been trying to contact MD-1 to get a new prescription written. They had taken R50 to see MD-1 this morning and it took until now to get the Methadone for the patient. RN-A stated R50 had been offered acetaminophen over the weekend. RN-A was not aware of any cold turkey (abruptly stopping medication) concerns regarding Methadone and staff were not monitoring for any of these concerns other than pain.
- At 4:45 p.m. LPN-A stated that the label from the medication card should be pulled and faxed to the pharmacy when there are 7 days left of the medication.
- At 4:45 p.m. Interim director of nursing (DON) stated she was not aware of any cold turkey concerns with abruptly stopping Methadone.
- At 4:55 p.m. R50 stated that staff did not make it clear to him that if he choose not to go to ER that he would not have Methadone available until Monday. He stated that staff assured him they were working on getting the medication filled.

On 10/30/18, at 8:09 a.m. DON stated that R50 is on the lowest dose of Methadone and he would let staff know if her were experiencing any withdrawal symptoms. DON could not provide any documentation that withdrawal symptoms were communicated to staff or R50.
- At 8:30 a.m. telephone interview with pharmacist from Thrifty White stated that he originally received a request from the nursing home to re-fill R50's Methadone on 10/18/18. Pharmacist stated that a fax was sent to the prescribing MD on 10/18/18, 10/26/18, & 10/29/18. Pharmacist stated he would be very concerned with withdrawal symptoms when a person abruptly stops taking Methadone - these

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symptoms can be very serious and harmful to the person.
- At 9:05 a.m. R50 stated he had lower back pain and the Methadone helps with pain. He stated he didn't think he was "going to make it" over the weekend as the pain was so bad. I did not sleep Saturday and Sunday night for 48 hours straight. Staff kept telling me they were calling about getting his Methadone. They gave me Tylenol but that didn't help. They did not try to get me anything else for the pain and I asked many, many times and they said they couldn't get anything. What if I was dying, do I just die in pain? It made me feel sad and angry. I asked for an extra Ativan (anti anxiety medication) to help me sleep and they said they did not have an order to do that. They did not tell me that if I did not go to ER that I would not have Methadone until Monday. The did not explain any withdrawal symptoms but I think that probably is what a lot of this was. R50 stated he received two doses of Methadone yesterday and was able to sleep last night.

Fax confirmation of nursing home re-order, received on 10/30/18, confirmed that Methadone refill for R50 was sent to pharmacy on 10/18/18.

Reiview of E-Mar indicated that R50 received acetaminophen 650mg as follows:
- 10/27/18 at 1:22 p.m. for pain due to being out of Methadone
- 10/27/18 at 5:22 p.m. for pain 7/10
- 10/28/18 at 12:56 a.m. for pain 7/10 affecting sleep
- 10/28/18 at 8:32 a.m. for pain 5/10
- 10/29/18 at 12 midnight for pain 7/10 affecting sleep

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Physician's Progress note dated 10/29/18, indicated patient here for follow-up on chronic pain - back pain. Has been on Methadone for the last few months. Patient has been out of his Methadone and requested medication be restarted. Chronic pain, discussed options of tapering and discontinuing Methadone. Patient reports significant distress on any attempted taper. Pros and cons discussed and Methadone refilled for the patient.

Appointment Transfer Sheet dated 10/30/18, with pain management MD-3 indicated increase pain without Methadone, could not function, sleep. Will resume Methadone, narcotic contract. Ordered Methadone 5mg TID and Tramadol 50 mg one tablet every 12 hours PRN for breakthrough pain.

Message was left with MD-B's office on 10/30/18, at 8:45 a.m.

Progress notes for R50 reviewed from 10/18/18 to present were absent of any notations (except above on 10/27/18) regarding R50 being without Methadone and what the facility did to rectify the situation. No indication that the facility made a request for additional medications that could have been helpful during the time R50 was without methadone or that R50 was educated on withdrawal symtpoms that could occur and that he should report to staff.

Review of Medication Policy reviewed/amended 1/2016, directed the night nurse go through the medication carts and reorder as needed for Narcotics. This is scheduled every Sunday and Thursday.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 742	Continued From page 15	F 742		

Review of undated Pain Management Policy indicated:
- residents receiving pain management interventions will be monitored for pain levels on a scheduled basis, and/or PRN, using the appropriate scale.
- any residents routinely receiving a scheduled or PRN analgesic will be reassessed for appropriateness and effectiveness at periodic intervals. Potential adverse consequences associated with medications will be monitored and addressed.
- the physician will be notified when pain persists or reoccurs despite treatment or if suspected adverse consequences are noted.

According to http://methadoneclinic.com quitting methadone cold turkey (abruptly) that there will be intense withdrawal symptoms. These range from mild to severe:
Mild symptoms include sensitivity to light, runny nose, fever, chills, sweating, increased pain sensitivity, jitteriness or tremors, restlessness, lethargy, agitation or nervousness.
Severe symptoms include suicidal thoughts or actions, hyperventilation, severe anxiety and depression, insomnia lasting as long as three weeks, severe pain in the abdomen, joints and legs, visual, auditory and olfactory hallucinations, irregular heartbeat and blood pressure, severe itching, panic, paranoid delusions and anorexia. Stopping methadone completely suddenly can cause permanent mental disability, heart attack, seizures and sometimes death. Quitting cold turkey is very dangerous because it all but guarantees that the user will experience most if not all of the withdrawal side effects to the extreme. There is evidence of patients going clinically insane after suddenly stopping

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	245252	A. BUILDING _____ B. WING _____	R 10/31/2018

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F 742	Continued From page 16 methadone and many of the withdrawal side effects are considered permanent damage. After completion of the survey on 11/1/18, at 1:15 p.m. MD-B returned phone call. MD-B stated absolutely this resident could have experienced withdrawal symptoms by not being provided his ordered methadone for 9 doses. MD-B also stated that his office had not been contacted by either the nursing home facility or the pharmacy requesting a re-fill of R50's methadone in the past 17 days. MD-B stated that his personal policy for re-filling medications is within 24-48 hours of being contacted. MD-B stated this was an unfortunate incident that should not have happened to R50.	F 742		

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{E 000}	Initial Comments An onsite revisit was conducted on October 29-31, 2018, to determine compliance with CMS Appendix Z Emergency Preparedness Requirements cited on August 31, 2018. The facility is now in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post-certification revisit was completed on October 29-31, 2018 to determine the status of Federal deficiencies issued during a recertification survey exited on 8/31/18. The facility was found to have corrected all deficiencies issued. However, additional deficiencies were identified. As a result, the facility has not achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The findings are delineated in this document. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		11/16/18

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

Electronically Signed | 11/19/2018

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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F 697	Continued From page 1 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident reviewed for pain (R50) received a prescribed pain medication in order to ensure pain relief. This failure resulted in actual harm to R50 who due to an abrupt discontinuation of routinely scheduled pain medication, suffered increased pain, increased anxiety, and insomnia. Findings include: R50's quarterly Minimum Data Set (MDS) assessment dated 7/31/18, indicated R50's diagnoses included: intervertebral disc degeneration lumbar region, pain, generalized anxiety disorder, and major depressive disorder. The MDS also indicated R50 had intact cognition, experienced frequent pain which made it hard to sleep and limited day to day activities. R50 required scheduled and as needed (PRN) medication. R50 rated the pain as a 7 out of 10 (with 10 being the most severe) pain level. R50's Pain Care Area Assessment (CAA) dated 2/13/18, indicated R50 stated he had always had chronic pain in his back which he rated a 7 out of 10. R50 stated the pain had kept him from sleeping at night and it also made it difficult to get out of bed and move around. R50 received Methadone 10 milligrams (mg) three times per day (TID) and Tylenol PRN which he had used almost daily within the MDS reference period. R50's general nursing observation started on	F 697	F697 Pain Management Thief River Care Center□s goal is to ensure all residents with pain receive their prescribed pain medication in order to ensure pain relief. R50 was sent into Urgent Care on Monday, 10/29/18 at 8A. When the resident returned from Urgent care at 9:30 AM where he saw his primary physician, he had not received any pain medication while he was there and when checked, the script had not been sent to Pharmacy yet. (The Pharmacy indicated on 10/29/18 they had sent a request 3 times since 10/18/18 to the physician for a script to refill the narcotic medication, and had not received one). The Nurse Manager went to the clinic in person at 1:20PM and then on to the Pharmacy to get the medication on 10/29/18 to ensure the resident finally received his pain medication. The Nurse Manager then contacted the Pain Clinic MD who visits the local clinic one time a month and made an emergency appointment for the R50 for 10/30/18. At this visit, an additional PRN narcotic pain medication (Tramadol) was prescribed in addition to his scheduled Methadone. All residents with P/Os for a narcotic pain medication have the potential to be affected. All residents with a P/O for a narcotic pain medication and current pain level of >5/10 (more than mild pain) were	

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F 697	Continued From page 2 7/31/18, and completed on 8/1/18, indicated R50 stated he always had chronic pain in his back and rated his pain within the last week at a 7 out of 10 on a 0-10 scale, with 10 being the worst. R50 stated the pain kept him from sleeping at night and it also made it difficult to get out of bed and move around. R50 received Methadone 5 mg (TID), BioFreeze ointment and Tylenol PRN. He had Tylenol three times during the observation reference period. R50 stated the pain medications helped relieve his pain. R50's care plan provided on 10/30/18, indicated R50 had chronic pain related to disc degeneration, lumbar region. Goal: resident would remain comfortable from pain, daily. Approaches included: administer analgesics per medical doctor (MD) orders, observe signs and symptoms of pain (grimacing, moaning, guarding) and report to MD as needed, use 0-10 pain scale to determine pain level and effectiveness of medication. R50's Physician orders dated 10/30/18, indicated the following medications for pain control: Methadone HCL (a narcotic used to relieve severe pain) 5 milligrams (mg) by mouth TID (three times a day) at 8 a.m., 2 p.m., and 8 p.m. Acetaminophen extended release 650 mg - 1 tablet two times per day (BID) at 6 a.m. and 8 p.m. Acetaminophen 650 mg every four hours PRN. The Sanford Telephone Encounter form dated 10/27/18, at 9:51 a.m. revealed a nurse from the facility had attempted to obtain a refill of R50's Methadone. The telephone encounter indicated the nurse had contacted MD-2, the on-call	F 697	reviewed and reassessed utilizing the Pain QAPI Audit tool on 11/1/18. The Medication policy was reviewed and revised to include the process for reordering of narcotic medications. This will now include contacting the care center□s Medical Director when there is 3 days of narcotic medication left and the Pharmacy had not received a script for the medication refill. The Medical Director will then contact the Primary Care Physician to obtain a script. Nursing staff were re-educated on Pain management, appropriate use of the Pain scale and the updated Medication policy regarding reordering Narcotic medications on 11/15/18. DON/designee will conduct audits of all residents with pain levels of > 5/10, 2X wk X4, then weekly x 4 and monthly thereafter. As a result of each individual Pain QAPI assessment, a plan to bring pain level down to less than 5/10 or within the resident□s goal for their pain level, will be addressed. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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provider for the nursing home this weekend and he was not willing to write a prescription for R50's Methadone refill and advised that R50 be seen in the emergency room in order to obtain the prescription. However, the facility nurse stated she did not have a way to get R50 to the emergency room.

R50's Progress Note written on 10/27/18, at 11:06 p.m. indicated when the author of the note had started her shift at 6:30 a.m., it was passed on to her in report that R50 was out of his scheduled pain medication: Methadone. The treatment nurse called the pharmacy in which the pharmacist stated they did not have a current prescription for the medication refill. The treatment nurse had then called the on-call MD-2 who stated he could not help due to R50 not being his patient. MD-1 (resident's MD) was unavailable for the weekend. MD-2 stated R50 would have to go to the emergency room /urgent care in order to obtain/receive the medication. Resident refused. Nothing can be done until Monday.

On 10/29/18, at 4:10 p.m. licensed practical nurse (LPN)-A verified R50's Methadone 5 mg TID order per the electronic medication administration record (E-Mar) which indicated R50 had not received the medication since the 2 p.m. dose on 10/26/18, (Friday). He had missed nine doses total up to this time.

During interview with R50 at 4:12 p.m. on 10/29/18, R50 stated he was "not good" as the facility had run out of his pain medication and he had not slept for 48 hours straight, and could not complete his physical therapy because of pain. R50 also stated he had PTSD (post traumatic

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stress disorder) from the Vietnam War. R50 stated the staff told him he could have gone to the emergency room/urgent care on Saturday in order to get pain medication however, he did not go because the staff had told him they had been working on getting his medication. R50 stated he had seen MD-1 at 9:30 a.m. this morning, and MD-1 had stated he had not been notified by either the facility, or the pharmacy, that a new prescription for the Methadone was needed in order to refill it.

During interview with registered nurse (RN)-A at 4:30 p.m. on 10/29/18, RN-A stated it was her understanding the pharmacy and the facility staff had been trying to contact MD-1 in order to obtain an updated prescription. RN-A confirmed R50 had been taken to see MD-1 this morning and verified it had taken until now (4:30 p.m.), to get the Methadone prescription to the facility. RN-A stated R50 had been offered acetaminophen over the weekend.

LPN-A was interviewed at 4:45 p.m. on 10/29/18 and stated the Methadone medication card, which held R50's individual tablets, had a peel off label which was to be peeled off and faxed to the pharmacy for refill seven days prior to the medication running out. A fax confirmation of nursing home re-order received on 10/30/18, confirmed the Methadone refill for R50 had been sent to the pharmacy on 10/18/18.

On 10/29/18, at 4:55 p.m. R50 stated the staff had not made it clear to him that if he chose not to go to the ER he wouldn't have the Methadone available until Monday. R50 stated the staff assured him they were working on getting the medication filled which was why he did not go to

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the emergency room/urgent care.

On 10/30/18, at 8:30 a.m. the pharmacist was interviewed by telephone. The Thrifty White pharmacist stated he had originally received a request from the nursing home to refill R50's Methadone on 10/18/18, and a fax had been sent to the prescribing MD on 10/18/18, 10/26/18, & 10/29/18, requesting a prescription to refill the medication.

On 10/30/18, at 9:05 a.m. R50 stated he had lower back pain and the Methadone had helped relieve the pain. R50 stated on the weekend he did not think he was "going to make it" because the pain was so bad. R50 said he had not slept Saturday or Sunday and was awake for 48 hours straight. R50 stated the staff kept telling him they were calling about getting his Methadone filled and acknowledged they had given him Tylenol but stated that did not help with the pain. R50 stated even though he had asked many, many times, the staff did not attempt to get him anything else for the pain because they said they could not get anything. R50 said, "What if I was dying, do I just die in pain? It made me feel sad and angry." R50 stated he had asked for an extra Ativan to help him sleep and the staff informed him they did not have an order to give him an extra dose. Again R50 verfied the staff had not told him that if he did not go to the emergency room, he would not have the Methadone until Monday. R50 stated he had received two doses of Methadone yesterday (10/29/18) and was able to sleep last night. He said when he had asked for his third dose at 3 a.m. today he was told he could not have it until 7:00 a.m.. R50 then stated he had asked for his Methadone at 7:30 a.m. today but did not get it until 9 a.m. At this time, R50 rated his pain at a

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7 out of 10 on the pain scale.

On 10/30/18, at 9:25 a.m. LPN-B confirmed R50 had received his Methadone at 8:47 a.m. that morning, and verified she had not asked him to rate his pain at that time. LPN-B stated the staff only asked/assessed for the resident pain rate when administering PRN medications.

Review of the E-Mar indicated R50 received acetaminophen 650 mg as follows:

- 10/27/18 at 1:22 p.m. for pain due to being out of Methadone
- 10/27/18 at 5:22 p.m. for pain 7/10
- 10/28/18 at 12:56 a.m. for pain 7/10 affecting sleep
- 10/28/18 at 8:32 a.m. for pain 5/10
- 10/29/18 at 12 midnight for pain 7/10 affecting sleep

R50's Physician's Progress note dated 10/29/18, indicated patient here for follow-up on chronic pain - back pain. Has been on Methadone for the last few months. Patient has been out of his Methadone and requested the medication be restarted. Methadone refilled for the patient.

An Appointment Transfer Sheet note dated 10/30/18, with pain management MD-3, indicated: "increased pain without Methadone, could not function or sleep. Will resume Methadone, narcotic contract. Ordered Methadone 5 mg TID and Tramadol 50 mg one tablet every 12 hours PRN for breakthrough pain."

On 10/30/18, at 8:45 a.m. a call was made to MD-1, and a message was left.

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Progress notes for R50 reviewed from 10/18/18, to present were absent of any notations (except above on 10/27/18) regarding R50 being without Methadone and what the facility did to obtain pain medication/relief. No evidence was available to indicate whether the facility had made a request for additional medications that could have been helpful during the time R50 was without his methadone

Review of the facility's Medication Policy reviewed/amended 1/2016, indicated the night nurse was to go through the medication carts and reorder as needed for Narcotics. "This is scheduled every Sunday and Thursday."

Review of the facility's undated Pain Management Policy indicated:
"...residents receiving pain management interventions would be monitored for pain levels on a scheduled basis, and/or PRN, using the appropriate scale.
- any residents routinely receiving a scheduled or PRN analgesic would be reassessed for appropriateness and effectiveness at periodic intervals. Potential adverse consequences associated with medications would be monitored and addressed.
- the physician would be notified when pain persists or reoccurs despite treatment or if suspected adverse consequences are noted."

Attempts to reach MD-1 during the survey were unsuccessful. Upon completion of the survey on 11/1/18, at 1:15 p.m. MD-1 returned a phone call. MD-1 stated in the past 17 days, his office had not been contacted by either the nursing home facility or the pharmacy requesting a re-fill of R50's Methadone. MD-1 stated his personal

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F 697	Continued From page 8 policy for re-filling medications was within 24-48 hours of being contacted. MD-1 stated this was an unfortunate incident that should not have happened to R50.	F 697		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pain medication was available to be administered as prescribed for 1 of 1 resident (R50) with chronic pain and whose narcotic pain medication was not refilled timely resulting in nine consecutive missed doses. This failure resulted in actual harm due to R50 experiencing increased pain, anxiety, and insomnia. Findings include: R50's quarterly Minimum Data Set (MDS) assessment dated 7/31/18, indicated R50's diagnoses included: intervertebral disc degeneration lumbar region, pain, generalized anxiety disorder, and major depressive disorder. The MDS also indicated R50 had intact cognition, experienced frequent pain which made it hard to sleep and limited day to day activities. R50 required scheduled and as needed (PRN) medication. R50 rated the pain as a 7 out of 10 (with 10 being the most severe) pain level. R50's Physician orders dated 10/30/18, indicated the following medications for pain control:	F 760	F760 Significant Medication Errors TRCC's goal is to ensure residents with pain have their pain medication refilled timely and available in order to ensure pain relief. R50's pain medication was obtained from the Pharmacy. All other residents receiving Narcotics have the potential to be affected and were reviewed to ensure an adequate supply of their narcotic medication was on hand. The Medication policy regarding ordering of Narcotic medications was reviewed and revised. Nursing and Trained Medication staff were re-educated on Pain management and the updated Medication policy regarding reordering of Narcotic medications, on 11/15/18. DON/designee will conduct random audits of residents with narcotic medications to ensure adequate supply, 2X wk X4, then weekly x 4 and monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	11/16/18

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Methadone HCL (a narcotic used to relieve severe pain) 5 milligrams (mg) by mouth TID (three times a day) at 8 a.m., 2 p.m., and 8 p.m.
Acetaminophen extended release 650 mg - 1 tablet two times per day (BID) at 6 a.m. and 8 p.m.
Acetaminophen 650 mg every four hours PRN.

The Sanford Telephone Encounter form dated 10/27/18, at 9:51 a.m. revealed a nurse from the facility had attempted to obtain a refill of R50's Methadone. The telephone encounter indicated the nurse had contacted MD-2, the on-call provider for the nursing home this weekend and he was not willing to write a prescription for R50's Methadone refill and advised that R50 be seen in the emergency room in order to obtain the prescription. However, the facility nurse stated she did not have a way to get R50 to the emergency room.

R50's Progress Note written on 10/27/18, at 11:06 p.m. indicated when the author of the note had started her shift at 6:30 a.m., it was passed on to her in report that R50 was out of his scheduled pain medication: Methadone. The treatment nurse called the pharmacy in which the pharmacist stated they did not have a current prescription for the medication refill. The treatment nurse had then called the on-call MD-2 who stated he could not help due to R50 not being his patient. MD-1 (resident's MD) was unavailable for the weekend. MD-2 stated R50 would have to go to the emergency room /urgent care in order to obtain/receive the medication. Resident refused. Nothing can be done until Monday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	R 10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(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 760	Continued From page 10	F 760		

On 10/29/18, at 4:10 p.m. licensed practical nurse (LPN)-A verified R50's Methadone 5 mg TID order per the electronic medication administration record (E-Mar) which indicated R50 had not received the medication since the 2 p.m. dose on 10/26/18, (Friday). He had missed nine doses total up to this time.

On 10/29/18, at 4:12 p.m. R50 stated he was "not good" as the facility had run out of his pain medication and he had not slept for 48 hours straight, and could not complete his physical therapy because of pain. R50 stated the staff told him he could have gone to the emergency room/urgent care on Saturday in order to get pain medicaiton however, he did not go because the staff told him they'd been working on getting his medication. R50 stated he had seen MD-1 at 9:30 a.m. this morning, and MD-1 had stated he had not been notified by either the facility, or the pharmacy, that a new prescription for the Methadone was needed in order to refill it. R50 stated this same thing had happened 2-3 months ago with his Ativan medication (antianxiety).

On 10/29/18, at 4:30 p.m. registered nurse (RN)-A stated it was her understanding the pharmacy and the facility staff had been trying to contact MD-1 in order to obtain an updated prescription. RN-A confirmed R50 had been taken to see MD-1 this morning and verified it had taken until now (4:30 p.m.), to get the Methadone prescription to the facility. RN-A stated R50 had been offered acetaminophen over the weekend and was not aware of any cold turkey (abruptly stopping medication) effects regarding Methadone use therefore the staff were not monitoring for any of these concerns, other than pain.

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F 760	Continued From page 11	F 760		

On 10/29/18, at 4:45 p.m. LPN-A stated the Methadone medication card, which held R50's individual tablets, had a peel off label which was to be peeled off and faxed to the pharmacy for refill seven days prior to the medication running out. A fax confirmation of nursing home re-order received on 10/30/18, confirmed the Methadone refill for R50 had been sent to the pharmacy on 10/18/18.

On 10/29/18, at 4:45 p.m. the director of nursing (DON) verified she was not aware of any side effects related to the abrupt discontinuation of Methadone.

On 10/29/18, at 4:55 p.m. R50 stated the staff had not made it clear to him that if he chose not to go to the ER he wouldn't have the Methadone available until Monday. R50 stated the staff assured him they were working on getting the medication filled which was why he did not go to the emergency room/urgent care.

On 10/30/18, at 8:09 a.m. the DON stated R50 was on the lowest dose of Methadone and he would have let the staff know if he was experiencing any withdrawal symptoms. The DON could not provide any documentation/evidence that potential withdrawal symptoms for monitoring had been communicated to staff or R50.

On 10/30/18, at 8:30 a.m. the pharmacist was interviewed by telephone. The Thrifty White pharmacist stated he had originally received a request from the nursing home to refill R50's Methadone on 10/18/18, and a fax had been sent to the prescribing MD on 10/18/18, 10/26/18, &

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F 760	Continued From page 12	F 760		

10/29/18, requesting a prescription to refill the medication. The pharmacist stated he would be very concerned with withdrawal symptoms for a person who abruptly stopped taking Methadone because the symptoms could be very serious and harmful to the person. When asked, the pharmacist confirmed R50's increased anxiety, uncontrolled pain, and insomnia could have been caused and exacerbated by the abrupt withdrawal of the Methadone.

On 10/30/18, at 9:05 a.m. R50 stated he had lower back pain and the Methadone helped relieve the pain. R50 stated on the weekend he did not think he was "going to make it" because the pain was so bad. R50 said he had not slept Saturday or Sunday and was awake for 48 hours straight. R50 stated the staff kept telling him they were calling about getting his Methadone filled and acknowledged they had given him Tylenol but stated that did not help with the pain. R50 stated even though he had asked many, many times, the staff did not attempt to get him anything else for the pain because they said they could not get anything. R50 said, "What if I was dying, do I just die in pain? It made me feel sad and angry." R50 stated he had asked for an extra Ativan to help him sleep and the staff informed him they did not have an order to give him an extra dose. Again R50 verfied the staff had not told him that if he didn't go to the emergency room, he wouldn't have the Methadone until Monday. When asked, R50 stated the staff had not informed him of the potential Methadone withdrawal symptoms to watch for but he thought his increased anxiety and inability to sleep for 48 hours could have been due to the abrupt discontinuation of the medication. R50 stated he had received two doses of Methadone yesterday (10/29/18) and

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F 760	Continued From page 13	F 760		

was able to sleep last night. He said when he'd asked for his third dose at 3 a.m. today he was told he could not have it until 7:00 a.m.. R50 then stated he had asked for his Methadone at 7:30 a.m. today but did not get it until 9 a.m. At this time, R50 rated his pain at a 7 out of 10 on the pain scale.

On 10/30/18, at 9:25 a.m. LPN-B confirmed R50 had received his Methadone at 8:47 a.m. that morning, and verified she had not asked him to rate his pain at that time. LPN-B stated the staff only asked/assessed for the resident pain rate when administering PRN medications.

Review of the E-Mar indicated R50 received acetaminophen 650 mg as follows:

- 10/27/18 at 1:22 p.m. for pain due to being out of Methadone
- 10/27/18 at 5:22 p.m. for pain 7/10
- 10/28/18 at 12:56 a.m. for pain 7/10 affecting sleep
- 10/28/18 at 8:32 a.m. for pain 5/10
- 10/29/18 at 12 midnight for pain 7/10 affecting sleep

R50's Physician's Progress note dated 10/29/18, indicated patient here for follow-up on chronic pain - back pain. Has been on Methadone for the last few months. Patient has been out of his Methadone and requested the medication be restarted. Methadone refilled for the patient.

An Appointment Transfer Sheet note dated 10/30/18, with pain management MD-3, indicated: "increased pain without Methadone, could not function or sleep. Will resume Methadone, narcotic contract. Ordered Methadone 5 mg TID

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F 760	Continued From page 14	F 760		

and Tramadol 50 mg one tablet every 12 hours PRN for breakthrough pain."

On 10/30/18, at 8:45 a.m. a call was made to MD-1, and a message was left.

Progress notes for R50 reviewed from 10/18/18, to present were absent of any notations (except above on 10/27/18) regarding R50 being without Methadone and what the facility did to obtain pain medication/relief. No evidence was available to indicate whether the facility had made a request for additional medications that could have been helpful during the time R50 was without his methadone, or to identify whether R50 had been educated on withdrawal symptoms that could occur that he should report to staff.

Review of the facility's Medication Policy reviewed/amended 1/2016, indicated the night nurse was to go through the medication carts and reorder as needed for Narcotics. "This is scheduled every Sunday and Thursday."

Review of the facility's undated Pain Management Policy indicated:
"...residents receiving pain management interventions would be monitored for pain levels on a scheduled basis, and/or PRN, using the appropriate scale.
- any residents routinely receiving a scheduled or PRN analgesic would be reassessed for appropriateness and effectiveness at periodic intervals. Potential adverse consequences associated with medications would be monitored and addressed.
- the physician would be notified when pain persists or reoccurs despite treatment or if suspected adverse consequences are noted."

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F 760	Continued From page 15 Attempts to reach MD-1 during the survey were unsuccessful. Upon completion of the survey on 11/1/18, at 1:15 p.m. MD-1 returned a phone call. When asked, MD-1 verified "absolutely" that R50 could have experienced withdrawal symptoms by not being provided his ordered methadone for nine doses. MD-1 stated that R50's uncontrolled pain, increased anxiety and insomnia could all have been withdrawal symptoms. Further, MD-1 also stated in the past 17 days, his office had not been contacted by either the nursing home facility or the pharmacy requesting a re-fill of R50's Methadone. MD-1 stated his personal policy for re-filling medications was within 24-48 hours of being contacted. MD-1 stated this was an unfortunate incident that should not have happened to R50. .	F 760		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YIOF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00448

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245252**

2.STATE VENDOR OR MEDICAID NO.
(L2) **591605000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THIEF RIVER CARE CENTER**
(L4) **2001 EASTWOOD DRIVE**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2006**

6. DATE OF SURVEY **08/31/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
04/30

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

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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 :
Debra Vincent, HFE - NE II 10/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/29/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 18, 2018

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: Project Number S5252028

Dear Administrator:

On August 31, 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 attached CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date;

Appeal Rights – the facility rights to appeal imposed remedies; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: pam.kerssen@state.mn.us
Phone: (218) 308-2129
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 483.12, Freedom from Abuse, Neglect, and Exploitation, 483.24, Quality of Life, 483.25, Quality of Care, 483.40 Behavioral Health Services, 483.45 Pharmacy Services, 483.70 Administration, or 483.80 Infection control; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

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

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective November 18, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 18, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 18, 2018.

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.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 18, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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 EIGHTIETH DAY OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 16, 2018 (80 days after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This discretionary denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This discretionary denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 1, 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.

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

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING Received 9/26/2018 B. WING	08/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(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 with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/27/18-8/31/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039	Approved LB 10/15/2018	10/17/18

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

Electronically Signed | 09/26/2018

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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E 039	Continued From page 1 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community and/or individual facility based exercise training program to test their emergency preparedness program. This had the potential to affect all 67 residents who currently resided in the facility, along with staff who work in the facility. Findings include:	E 039	E039: Thief River Care Center (TRCC) will conduct exercises to test the emergency plan at least annually. Thief River Care Center will conduct a full scale exercise by 10/17/18 and a table top exercise was conducted on 10/3/18. The results of the facilities response to the exercises have been analyzed and documented. TRCC Employees have been educated on the results of the	

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E 039	Continued From page 2 On 8/31/18, at 12:10 p.m. the administrator confirmed the facility had developed a training plan for emergency procedures but had not conducted any table top or full scale exercises in order to test the plan.	E 039	facilities response to the exercises by 10/17/18. The Administrator/designee will audit the EMR bi-annually for the full scale and table top exercise compliance. The results of the exercises conducted and the audits will presented to the QAPI committee for review and further recommendations as needed.	
F 000	INITIAL COMMENTS On August 31, 2018, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		10/17/18

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F 550	Continued From page 3 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure urinary catheter drainage bags were covered to maintain dignity for 2 of 2 residents (R59, R60) observed with uncovered urinary catheter drainage bags in view of residents, staff and visitors.	F 550	F550: TRCC will ensure each resident is treated in a manner that maintains their dignity. R59 and R60 had catheter drainage bag covers applied for wheelchair use and bed use.	

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F 550	Continued From page 4 Findings include: R59's quarterly Minimum Data Set (MDS) dated 5/22/18, indicated R59 had moderate cognitive impairment and diagnoses which included cerebral aneurysm, seizure disorder and depression. The MDS also indicated R59 was always incontinent of urine and bowel and a current toileting program or trial was not being used to manage R59's urinary continence. R59's Urinary Incontinence/Indwelling Catheter Care Plan dated 6/5/18, indicated R59 had an indwelling urinary catheter and directed staff to assess the catheter drainage system, assist R59 with good personal hygiene, change catheter system monthly, observe for signs and symptoms of infection and report changes, record intake and output and use flat pads to maintain skin integrity. The Care Plan did not address the promotion of dignity related to the urinary catheter. R59's General Nurse's Observation for Bladder dated 8/16/18, indicated R59 had a Foley catheter placed in June 2018 due to diarrhea and urine affecting skin integrity. On 8/30/18, at 11:18 a.m. R59 was observed resting in bed. A catheter drainage bag which contained clear, yellow urine was observed hanging uncovered, on the frame of the bed. The bag was visible from the door of R59's room. On 08/31/18, at 9:51 a.m. nursing assistant (NA)-B and NA-J were observed to perform morning cares for R59. R59's catheter drainage bag which contained clear, yellow urine was again observed to be hanging, uncovered, from the bed	F 550	All residents with catheter bags could be affected. An audit of all current residents who have catheter drainage bags was completed to ensure they had covers on them. Nursing staff were educated on the facility□s Dignity policy regarding catheter drainage bag covers, on 10/9/18. The DON/Designee will conduct random audits on residents with catheters to ensure they are covered, 2 residents 2X week for 4 weeks then weekly X 4 weeks and monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Completion date: 10/17/18	

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F 550	Continued From page 5	F 550		

frame and visible from R59's doorway.

R60's quarterly MDS dated 7/19/18, indicated R60 had moderate cognitive impairment and diagnoses which included neurogenic bladder, multiple sclerosis and seizure disorder. The MDS also indicated R60 had an indwelling catheter

R60's undated Care Plan indicated R60 was at risk for urinary tract infection related to neurogenic bladder as evidenced by R60's need for a suprapubic catheter. The Care Plan directed staff to implement interventions which included but were not limited to:
--clean suprapubic site daily
--report signs and symptoms of infection to site to physician
--empty drainage bag every shift and as needed
--irrigate catheter as ordered
--keep drainage bag covered at all times

On 8/29/18, at 2:20 p.m. R60 was observed resting in bed with eyes closed. An uncovered, urinary catheter drainage bag was hanging on the bed frame and contained clear, yellow urine. The drainage bag was in view of the common corridor/area.

On 8/30/18, at 7:51 a.m. R60 was observed resting in bed with eyes closed. An uncovered, urinary catheter drainage bag containing clear, yellow urine, hung on the bed frame. The drainage bag was again in view of the common corridor/area.

On 8/31/18, at 7:56 a.m. R60 was again observed resting in bed with her eyes open. An uncovered urinary catheter drainage bag, containing clear

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F 550	Continued From page 6	F 550		

yellow urine, hung on the bed frame. The bag was again visible from the common corridor/area.

--At 2:42 p.m. nursing assistant (NA)-K stated they had privacy bags in which to store the urinary catheter drainage bags when residents were up in a wheelchair. NA-K also stated if they had them available, they would also use them in the residents' rooms. NA-B confirmed R59 did not have a bag for use in her room, however, stated they usually left the door shut. NA-D indicated she had put a cover on R60's drainage bag today. At this time, R60's catheter bag was observed stored in a cloth bag and hung on the bed frame.

--At 4:22 p.m. registered nurse (RN)-A indicated they had privacy covers for urinary catheter drainage bags especially for use when residents were out of their room. RN-B confirmed uncovered urinary catheter drainage bags in view of residents, staff and visitors would be a dignity issue and verified the bags should have been covered.

The Dignity policy dated 10/23/17, indicated each resident would be treated with respect and dignity at all times. The policy indicated "treated with dignity" meant the resident would be assisted in maintaining and enhancing his or her self worth and staff would promote, maintain and protect resident privacy, including bodily privacy during assistance with personal cares and treatment procedures. The policy also indicated staff would provide care that could help avoid thing that could be demeaning to resident such as place catheter bags in a covered bag so they are not easily visualized.

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F 554	Continued From page 7	F 554		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment for safe self-administration of medications was completed for 1 of 1 resident (R34) observed to self-administer Keppra. Findings include: R34's annual Minimum Data Set (MDS) dated 7/10/18, indicated R34 had moderate cognitive impairment and diagnoses which included encephalopathy (broad term to describe brain disease, damage or malfunction), aphasia (loss of the ability to understand or express speech) and stroke. The MDS also indicated R34 required limited assistance with eating. R34's Physician Order Sheet dated 7/1/18, included an order for Keppra (levetiracetam) (an anti-seizure medication) solution 500 milligrams (mg)/milliliters (ml): administer 5 mls by mouth two times per day for epilepsy and recurrent seizures. The order start date was 3/14/18. R34's Care Plan reviewed 7/20/18, indicated R34 wanted to self-administer creams and lotions. The Care Plan directed staff it was nursing responsibility to document administration of lotion and/or cream, nursing to monitor R34's self medication administration and document and	F 554	F554: TRCC will ensure each resident is assessed to identify if they are clinically appropriate to self- administer their medications. A Self Administration of Medication (SAM) Assessment was completed for R34. The resident was identified to not be appropriate for self-administration of his oral medications. Nursing staff were re-educated on the facility□s policy on Self Administration of Medication by resident, and process to follow, on 10/9/18 and 10/12/18. All residents will be audited to ensure they have had a SAM Assessment completed, by 10/1/18. The DON/designee will audit the medication pass at random 2 times weekly x 4 then weekly X 4 and monthly thereafter, to ensure the self-administration of medications process is being followed. Audit results will be brought to the QAPI Committee quarterly for review and further recommendations. Completion date: 10/17/18	10/17/18

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R34's responsibility to store lotions and/or creams. The Care Plan did not address R34's ability to self administer anti-seizure medication.

R34's electronic medication administration record (EMAR) Monthly Report for August 2018 dated 8/1/18 to 8/31/18, indicated R34 received Keppra 500 mg/ml, 5 mls twice daily.

Review of R34's record revealed it lacked an assessment which indicated R34 could safely self-administer medication.

On 8/29/18 at 9:04 a.m. licensed practical nurse (LPN)-A removed R34's morning medications from the medication cart, dispensed finasteride 5 mg tablet and lisinopril 10 mg tablet into a medication cup. She then dispensed two extra strength gas relief chewable tablets into another medication cup and poured 5 mls of levetiracetam solution into a plastic medication cup. She then poured 30 mls of UTI-Stat (a urinary tract cleansing liquid) into another plastic medication cup and poured a small drinking cup approximately three quarters full of cranberry juice. LPN-A thickened the consistency of the cranberry juice and then poured the UTI-Stat into the glass of thickened cranberry juice. LPN-A brought the medications and glass of cranberry juice to R34 as he sat in the dining room eating breakfast. She first handed R34 the medication cup of levetiracetam solution and sat the glass of cranberry juice on the table in front of R34. R34 poured the levetiracetam solution into the glass of cranberry juice. LPN-A stirred the cranberry juice/medication cocktail with a spoon and then administered R34 the finasteride and lisinopril in a spoonful of pudding. LPN-A then assisted R34 to take the gas relief chewable tablets and

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returned to the medication cart without remaining until R34 finished the medication/cranberry juice mixture. R34 was continuously observed seated at the table eating breakfast.

--At 9:32 a.m. R34 pushed himself away from the table in his wheelchair and propelled himself with his feet out the door of the dining room. R34's thickened cranberry juice which contained levetiracetam remained approximately two thirds full. No staff were observed in or around the dining room at the time R34 left.

--At 9:39 a.m. LPN-A was asked to return to the dining room and observe R34's place setting. LPN-A verified R34 had poured his levetiracetam into the thickened cranberry juice and confirmed the glass of cranberry juice remained on the table unfinished by R34. LPN-A stated she would bring the juice to R34's room for him to finish.

--At 10:10 a.m. LPN-A indicated residents who were assessed to be able to self-administer medication had a notation on their record which would display on the EMAR and be visible during medication administration. LPN-A stated R34 had recently had a feeding tube and she doubted if he had such an assessment. LPN-A opened the computer program and verified R34's record did not contain an indication R34 could self-administer his medication.

--At 11:21 a.m. registered nurse (RN)-A verified R34 did not have an assessment which indicated he could self-administer medication.

On 8/30/18, at 3:23 p.m. the director of nursing (DON) verified LPN-A should have stayed with R34 until the juice with the medication had been

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F 554	Continued From page 10 finished. DON confirmed they would not have known how much of the anti-seizure medication R34 consumed and not receiving the full dose could impact the therapeutic level of the drug, which if too low, placed R34 at increased risk for seizures. DON confirmed R34 did not have an assessment which indicated he could safely self-administer medications. The Self-Administration of Medication by Residents policy dated 1/8/18, indicated if residents wished to self-administer medications, they would be assessed for their ability to safely self-administer their medications. A Self-Administration of Medications (SAM) assessment would be completed and reviewed by the IDT [interdisciplinary team]. The assessment included: cognitive status, physical status, which medications were appropriate to be self-administered, where the medications would be stored safely, how nursing staff would monitor the medication's use and how it would be documented. Nursing staff would ensure the EMAR and care plans reflected the resident's self-administration of medications.	F 554		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F 565		10/17/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 11 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to effectively respond to resident council grievances related to medication administration for 3 of 16 resident council members (R24, R14, R64) present during the resident council meeting. Findings include: Review of Resident Council meeting minutes from 2/21/18 to 7/25/18, identified the following: --5/23/18, meeting minutes identified 2 residents reported the nurses had been leaving their cup of	F 565	F565: TRCC will follow up in an effective manner on all concerns expressed by the Resident Council members. The concern expressed at the State□s Resident Council meeting by R24, R14 and R46 was followed up and corrective actions put in place. All nursing staff were re-educated regarding the residents concern on 10/9/18 and 10/12/18. The Resident Council policy was reviewed and revised to include □investigation of the concern to ensure it was not	

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F 565	Continued From page 12 medications without administering them. --6/20/18, meeting minutes identified a section entitled "Old Business" which included: Review of action forms: Nursing Response: A couple residents reported their meds were left in a cup and one resident could not pick up the cup to get them and the other stated she didn't know they were there until quite a while later. The director of nursing (DON) educated her staff and the residents reported it had not happened again. On 8/29/18, at 9:04 a.m. licensed practical nurse (LPN)-A removed R34's morning medications from the medication cart, dispensed finasteride 5 mg tablet and lisinopril 10 mg tablet into a medication cup. She then dispensed two extra strength gas relief chewable tablets into another medication cup and poured 5 mls of levetiracetam (Keppra-antiseizure medication) solution into a plastic medication cup. She then poured 30 mls of UTI-Stat (a urinary tract cleansing liquid) into another plastic medication cup and poured a small drinking cup approximately three quarters full of cranberry juice. LPN-A thickened the consistency of the cranberry juice and then poured the UTI-Stat into the glass of thickened cranberry juice. LPN-A brought the medications and glass of cranberry juice to R34 as he sat in the dining room eating breakfast. She first handed R34 the medication cup of levetiracetam solution and sat the glass of cranberry juice on the table in front of R34. R34 poured the levetiracetam solution into the glass of cranberry juice. LPN-A stirred the cranberry juice/medication cocktail with a spoon and then administered R34 the finasteride and lisinopril in a spoonful of pudding. LPN-A then assisted R34 to take the gas relief chewable tablets and returned to the medication cart without remaining	F 565	happening to other residents and may include all appropriate staff training□. All Department heads were educated on the revised policy and process for following up on Resident Council concerns. Resident Council members will be educated on the revised policy and process for follow up of resident concerns at the Resident Council meeting on 9/26/18. The Administrator/designee will audit Resident Council concerns to ensure adequate and appropriate follow up, 1 week after each monthly Resident Council meeting. Audit results and resident council concerns will be brought to the QAPI committee quarterly for review and further recommendations.	

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until R34 finished the medication/cranberry juice mixture. R34 was continuously observed seated at the table eating breakfast.

--At 9:32 a.m. R34 pushed himself away from the table in his wheelchair and propelled himself with his feet out the door of the dining room. R34's thickened cranberry juice which contained levetiracetam remained approximately two thirds full. No staff were observed in or around the dining room at the time R34 left.

--At 9:39 a.m. LPN-A was asked to return to the dining room and observe R34's place setting. LPN-A verified R34 had poured his levetiracetam into the thickened cranberry juice and confirmed the glass of cranberry juice remained on the table unfinished by R34. LPN-A stated she would bring the juice to R34's room for him to finish.

On 8/29/18, at 10:48 a.m. the resident council meeting was attended by several residents including R24, R14, R64. When asked about grievances, R24 complained of the facility practices regarding medication administration. R24 stated the nursing staff just leave the medication cup with the resident and do not stay to ensure the medications are taken. R24 stated she had complained about this before and it was a problem again. R24 then recounted an incident which she indicated occurred a couple of days prior when a nurse brought a bag of crushed meds into the dining room and placed them in her tablemate's beverage. R24 stated the nurse didn't even stir them and left the chunks of medication floating on top of the drink then left the table without ensuring the mediations were taken. R24 stated her tablemate then spilled her drink and had not received any of the medications. R14

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and R64 also agreed there had been issues with staff leaving medications with residents without ensuring they were taken. After R24 recounted the story, LPN-A entered the room and administered medication for a resident. R24 stated, "That is how is supposed to be done! She stayed to make sure the resident took her medications."

The Resident Council Action Form dated 5/25/18, indicated two residents R64 and R24 had reported the nurses had been leaving their cup of meds and not administering them. R64 was unable to take them herself and R24 stated she had been half asleep and unaware they left them on her table and she had found them later in the day. The response section dated 6/15/18, indicated staff had been talked to and instructed not to the leave meds, if continued to happen please talk to RN (registered nurse) manager.

On 8/31/18, at 1:30 p.m. director of nursing (DON) stated it had been one nurse who had been leaving the medications with the residents and walking away. DON stated she had provided verbal education with that nurse, however indicated she did not have any documentation of the education provided. DON indicated for follow up she had asked the one resident who had complained if the nurse was still doing it and the resident stated no. DON indicated no other follow up or auditing for compliance had been completed.

--At 5:33 p.m. the administrator indicated the facility did not have a specific policy related to following up of resident council grievances and indicated any concerns would be forwarded to appropriate department head for resolution. The

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F 565	Continued From page 15 concern would then be addressed at the next meeting to see if there had been resolution. The administrator indicated his expectation would be for staff to do an assessment to determine the scope of the problem and then implement monitoring and some type follow up such as periodic medication checks to ensure ongoing compliance. The administrator stated moving forward he would tie this type of concern into the facility Quality Assurance (QA) meetings.	F 565		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide financial record for resident fund accounts for 1 of 1 resident (R33) who requested balance on account and was not provided. Findings include: R33 stated on 8/27/18, at 2:15 p.m. "Well over a month ago I requested information related to	F 568	F568: TRCC ensures the personal fund record is available to each resident and/or appropriate representative through quarterly statements and upon request. R33 was provided with requested Personal Funds record during the survey. An audit of all residents for the past quarter to identify and ensure all residents had received their personal funds record, was completed on 8/31/18.	10/17/18

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F 568	Continued From page 16 transactions on my trust fund account. I spoke with the accountant in the business office and was told my trust fund information was not available at this time due to the facility going from one accounting system to another, and he would get back to me as soon as they had completed the process." R33 added, "I also called my son, and he had not received any information. I would like to know what transactions occurred to see where my money went." R33 stated she expected she would have received information related to her trust fund account by now. On 8/30/18, at 8:38 a.m. the accountant confirmed the facility was in the process of switching to a different system for the trust fund accounts. The accountant stated he would check the trust fund account and determine if a statement was provided. On 8/30/18, at 9:54 a.m. the accountant stated he was checking with activities to ensure all transactions are reflected on R33's trust fund account since her admission on 11/6/17. The accountant confirmed resident statements are to be provided on a quarterly basis and the process for changing accounting systems had been completed. The accountant stated he could not confirm R33 received her statement as requested. The accountant stated he would ensure R33 received a copy of her statement today and would answer any questions she had. The accountant stated going forward he will ensure each and every residents trust fund statements are provided or mailed to guardians. On 8/30/18, at 11:25 a.m. the administrator confirmed that R33 should have received her trust fund statement and the process will be	F 568	All residents and/or representatives will be mailed a copy of their statement on a quarterly basis and as directed by the facility□s Resident Trust Fund policy. The Facility□s Accountant was educated on the facility□s policy on Resident Trust Funds on 8/31/18. The Administrator/designee will audit the personal funds records randomly on a weekly basis and after the end of each quarter for compliance regarding distribution of Personal Funds statements, Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 568	Continued From page 17 corrected. The facility policy Resident Trust Fund, revised 4/6/15, indicated, electronic accounting software is currently used as the accounting software for the Resident Trust Fund and statements would be provided upon request, upon discharge, monthly if a resident's account falls below zero anytime during the month, quarterly to all residents regardless of their account balance, and upon death of a resident (final accounting).	F 568		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		10/17/18

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F 580	Continued From page 18 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician was notified timely of a change in condition related to increased verbal and non-verbal expressions of severe pain and behaviors for 1 of 1 resident (R5) who sustained a hip fracture. This failure resulted in actual harm for R5 whose treatment of her hip fracture was delayed for 22 days. Findings include: R5's quarterly Minimum Data Set (MDS) dated	F 580	F580: TRCC□s goal is to notify the physician of any significant change in the resident□s physical, mental or psychosocial status. R5□s Physician was notified of the resident□s change of condition regarding increased verbal and non-verbal expressions of pain on 8/1/18. An audit of all current residents with increased expressions of pain in order to identify a change in condition that would require physician notification, was completed by 10/1/18. Licensed Nursing staff were re-educated	

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F 580	Continued From page 19 5/29/18, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, anxiety disorder, psychosis and pain. The MDS indicated R5 required extensive assistance with activities of daily living (ADL), was non-ambulatory, and had no functional limitations in range of motion of her upper or lower extremities. The MDS further indicated R5 experienced no pain at the time of the assessment and had not received scheduled or as needed (PRN) pain medication. R5's Pain Care Area Assessment (CAA) dated 8/21/18, indicated R5 had no noticeable signs of pain noted no facial grimacing, moaning, calling out or restlessness. R5 denied pain upon interview. The CAA indicated R5 had been diagnosed with a right hip fracture on 8/10/18, for which the physician prescribed Tramadol (narcotic like pain reliever to treat moderate to severe pain) 50 milligrams (mg) three times daily PRN which she had received twice, along with extra strength Tylenol 1000 mg scheduled three times daily. Staff stated R5 sometimes complained of pain when repositioned or during dressing changes to her right heel. Staff also indicated R5 had no complaints of pain when seated in a Geri chair (large padded chair with wheeled base). Non-pharmacological interventions for pain included: warm/cool pack and repositioning. Goal for pain management was not to have pain which had been met and R5 was able to enjoy activities. R5's Care Plan reviewed 6/13/18, indicated R5 was able to express her needs and occasionally expressed pain. The Care Plan directed staff to provide medications as ordered and observe for signs and symptoms of discomfort and treat and	F 580	on the facility□s policy on physician notification of changes by 10/1/18. The DON/designee will audit the facility□s 24 hour report for changes in condition regarding pain and need for physician notification daily x 2 weeks then weekly X 4 weeks and monthly thereafter. Audits results will be brought to the QAPI Committee for review and further recommendations where necessary.	

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update provider as necessary. The Care Plan also indicated R5 was at risk for fall or injury related to cognitive deficits and directed staff to provide pain assessment and monitoring. The Care Plan further indicated R5 had behaviors which included calling out/disruptive noises, spitting out medications and refusing cares. The Care Plan directed staff to implement interventions which included:
--ask if there was anything needed/reason for calling out/disruptive noises
--attempt to meet R5's needs when calling out/disruptive noises
--monitor frequency of calling out/disruptive noises
--report all behaviors to the nurse to chart
--update physician as needed for behavior changes.

The Care Plan was updated 8/10/18, to indicate R5 had decreased mobility related to a non-surgical fracture of the right femur head and directed staff to assist as needed with mobility.

On 8/29/18, at 8:34 a.m. R5 was observed dressed and seated in a Geri chair in the dining room for breakfast. Staff observed to ask preferences for breakfast meal. R5 exhibited no verbal or non-verbal indicators of pain.
--At 12:11 p.m. R5 was seated in a Geri chair in dining room eating the noon meal with assistance from nursing assistant (NA)-L. R5 exhibited no verbal or non-verbal indicators of pain.
--At 2:23 p.m. R5 was observed resting in bed with the lights off. R5 was positioned on her right side. No verbal or non-verbal indicators of pain observed.

On 8/30/18, at 7:11 a.m. R5 was observed resting

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quietly in bed, positioned on her left side.
--At 7:13 a.m. NA-M entered R5's room and greeted R5. NA-M checked R5's incontinent brief, then assisted R5 to roll onto her back and NA-M lowered her pants and removed the brief. NA-M provided perineal care and provided cues and assistance for R5 to roll back again after assisting R5 to don a clean brief. Registered Nurse (RN)-A entered the room with mechanical lift and RN-A and NA-M transferred R5 to the Geri chair with the use of the lift. NA-M wheeled R5 into the bathroom, set up and provided cues for R5 to brush her teeth, comb her hair and wash her hands. R5 tolerated the cares and transfer well and did not express verbal or non-verbal signs of pain.

Review of R5's medical record revealed the following events and progression of verbal and non-verbal expressions of pain exhibited by R5:
--7/16/18, progress note (PN): R5 transferred to emergency room (ER) at 10:30 p.m. for evaluation.
--7/16/18, -7/17/18, ED [emergency department] note: diagnosed with urinary tract infection and prescribed antibiotic. Lab order identified urine collection was via straight catheter.
--7/17/18, PN at 2:37 a.m. returned from ER at 1:10 a.m..
--7/17/18, PN at 7:52 a.m. Fax communication sent to primary care physician (PCP) updating that R5 was sent to ER last evening returned diagnosis of urinary tract infection (UTI).
--7/17/18, PN at 2:15 p.m. transferred to urgent care at approximately 12:30 p.m..
--7/17/18, Urgent Care Note: transferred to urgent care at 12:30 p.m. for fatigue, somnolence and elevated blood sugar.
--7/17/18, PN at 3:37 p.m. returned to facility

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from ER visit. New orders continue Cipro (antibiotic) 500 mg twice daily for 7 days. Novolog (insulin) subcutaneous sliding scale, BMP [basic metabolic panel] (laboratory testing) and CBC [complete blood count] (laboratory testing) June [sic] 20th, 2018. Will update primary healthcare provider.
--7/17/18, PN at 6:46 p.m. Resident has been complaining of left leg pain. R5 also had a fever of 100.8 and was given Tylenol.
--7/19/18, at 2:03 p.m. PN: R5 complained of continuous right hip pain with gradual onset which has affected mobility. R5 hollered and moaned with movement and was given two Tylenol.
--7/19/18, PN at 8:59 p.m. pain control unrelieved by medication.
--7/19/18, PN at 9:00 p.m. resident verbalized knee pain.
--7/20/18, at 12:19 p.m. PN: verbalized hip pain.
--7/21/18, PN at 7:54 a.m. R5 developed a fluid filled blister to the right heel and the physician (MD) was notified via fax.
--7/21/18, PN at 1:50 p.m. MD in to the facility to see R5's right heel blister and recommended referral to Podiatry. MD was not notified of new onset of pain and right hip pain was not addressed.
--7/22/18, PN at 4:25 p.m. verbalized hip pain, repositioned for comfort.
--7/24/18, PN at 1:18 p.m. hip pain rated 9/10 (0 being no pain at all and 10 being the worst pain), screaming, moaning.
--7/25/18, PN at 1:23 p.m. hip pain rated 6/10, screaming, grimacing, and moaning.
--7/25/18, PN at 9:39 p.m. verbalized acute hip/leg pain rated 8/10.
--7/26/18, PN at 3:53 p.m. received orders from Podiatrist for right heel ulcer.
--7/27/18, PN at 6:49 p.m. back pain rated 5/10,

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unrelieved at 9:43 p.m..
--7/30/18, PN at 12:43 p.m. verbalized acute back pain/ache rated 6/10.
--7/30/18, Nursing Home Note: R5 seen by MD for routine visit. (However, MD was not notified of right hip pain and pain was not addressed).
--8/1/18, Nurse Communication to Physician Order: Situation/Background: R5 has been having right hip pain on and off for approximately 2 weeks. No injury. Unable to schedule appointment with you for 2 weeks. Would you like her to be seen in urgent care or can you fit her in? Physician/Provider Response: MD-A indicated: Please remind staff that this should be mentioned when I round. I saw her twice during the last couple weeks and this was not mentioned. I have openings next week or she can be seen in same day care.
--8/1/18, PN at 8:34 a.m. R5 continued to complain of right hip pain with no injury. Appointment scheduled for 8/3/18 with PCP. Notified daughter, she is unable to attend appointment.
--8/2/18, PN at 2:40 p.m. hip pain rated 6/10, moaning.
--8/3/18, PN at 10:52 p.m. leg pain rated 5/10.
--8/6/18, PN at 2:34 p.m. hip pain.
--8/6/18, PN at 10:52 p.m. hip and foot pain rated 7/10, restless, agitation, anxiety, screaming, grimacing, guarding or protecting body parts. Interventions included: worked with relaxation techniques, heat application given, repositioned for comfort. Pain unrelieved at 2:14 a.m.
--8/7/18, PN at 7:31 a.m. hip pain, grimacing.
--8/7/18, PN at 2:50 p.m. hip pain, restlessness, anxiety, withdrawal, screaming.
--8/8/18, PN at 11:15 a.m. She has been having right hip pain and has been receiving PRN Tylenol for pain control. Spoke with daughter

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about keeping her scheduled appointment for 8/14/18 or being seen sooner. She agreed she could be seen in Same Day Care on 8/10/18 and she will meet at the clinic.
--8/8/18, PN at 12:57 p.m. hip pain rated 7/10.
--8/8/18, PN at 5:55 p.m. hip pain rated 8/10.
--8/9/18, PN at 12:19 a.m. continuous hip, foot, and leg pain, limits mobility, change in mood, change in behavior, insomnia. Restlessness, anxiety, screaming and moaning. Two Tylenol given for complaint of pain in left hip and legs/feet. Resident was repositioned in bed and legs/feet were elevated due to increased edema. Music is turned on in room for distraction. Lights reduced to a minimum to promote sleep.
--8/9/18, PN at 6:57 a.m. hip pain rated 7/10.
--8/9/18, PN at 1:44 p.m. hip pain rated 6/10.
--8/10/18, PN at 7:52 a.m. hip pain rated 7/10, screaming, moaning.
--8/10/18, PN at 8:00 a.m. transported to urgent care for intermittent right hip pain at this time.

R5's Office Visit note dated 8/10/18, indicated R5 had been having problems with pain in her hip. Nobody was quite sure when it had begun. R5 complained of pain to right hip with movement but had no pain when not moved. X-rays were reviewed and R5 was noted to have osteopenia (condition in which bone mineral density is lower than normal) present and was noted to have a subcapital displaced femoral neck (extending through the junction of the head and neck of femur) fracture. The fracture margins were rounded and smoothed, suggestive that several weeks had passed since R5's fracture occurred. The physician's impression was subacute to possible chronic femoral neck fracture of right hip. The recommendation was non-surgical treatment.

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R5's electronic medication administration record (EMAR) Monthly Report for July 2018 and August 2018, included an order for acetaminophen 325 milligram (mg) administer 2 tablets by mouth as needed (PRN) every six hours for pain. No other orders for pain medication were available until 8/10/18, when the acetaminophen order was changed to 1000 mg 3 times daily for fracture of neck of right femur and a new order for Tramadol 50 mg PRN 3 times daily for fracture of part of neck of right femur was added.

R5's medical record revealed the following trend in R5's use of PRN acetaminophen.
7/1/18 to 7/15/18: 1 time
7/16/18 to 7/31/18: 13 times
8/1/18 to 8/10/18: 12 times

R5's Mood & Behavior - Incident Based report dated 7/1/18 to 8/31/18, indicated R5 exhibited such behaviors as verbal and physical aggression, yelling, insomnia, anxious complaints, repetitive verbalizations, and unpleasant mood. The report revealed the following trend in R5's behaviors:
--7/1 to 7/15: 11 instances of behaviors
--7/16 to 7/31: 11 instances of behaviors
--8/1 to 8/15: 24 instances of behaviors
--8/16 to 8/31: 9 instances of behaviors

R5's record lacked a comprehensive assessment of R5's increased pain and behaviors to triage the immediacy of need for intervention and treatment.

On 8/30/18, at 1:51 p.m. licensed practical nurse (LPN)-A stated R5 went through phases of being extremely tired, to hollering out, to periods of contentment. LPN-A indicated she was not

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aware of R5's hip fracture. LPN-A stated they had increased R5's Tylenol lately and she seemed better. LPN-A indicated R5 used to be awake at night and more restless during the day but she seemed to be better with pain. LPN-A also stated R5 was not really able to express her pain so they looked for pain indicators such as restlessness, yelling out, grimacing and not sleeping at night.

--At 1:57 p.m. nursing assistant (NA)-M stated R5 had been about the same as before before they identified her hip fracture. NA-M stated R5 seemed content and happy now. NA-M indicated she could not speak to how R5 was right before the hip fracture was identified and stated she had not noticed any major differences.

--At 2:01 p.m. NA-N and NA-L stated R5 did more hollering in the evening and sometimes in the early morning. NA-L indicated she also worked as a trained medication assistant (TMA) and stated R5 had complained of hip pain and could tell them the hip was hurting before the fracture was identified. NA-L indicated they tried non-pharmacological interventions for pain and she had been receiving Tylenol, which seemed to help. NA-L stated the hip pain had been something new R5 had not complained of before.

--At 2:06 p.m. registered nurse (RN)-A confirmed R5 had an emergency room (ER) visit on 7/17/18 for a urinary tract infection and also had been seen in urgent care for high blood pressure on that date. RN-A confirmed R5 had complained of leg pain on 7/17/18, and had first complained of right hip pain on 7/19/18. RN-A verified R5 then developed a blister on her right heel on 7/21/18 and had been seen by MD-A on that date. RN-A

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confirmed MD-A had not addressed R5's right hip pain at that time. RN-A verified MD-A had again seen R5 on 7/30 but had not addressed the hip pain. RN-A stated they had made an appointment for R5 to be seen on 8/3/18, however the daughter was unable to attend and the appointment was rescheduled for 8/13/18. RN-A indicated they had been able to get an earlier appointment and R5 was seen on 8/10/18. RN-A indicated there was no documentation of an injury or accident for R5.

--at 2:51 p.m. the director of nursing (DON) clarified R5's 8/3/18 appointment had been canceled by MD-A. DON verified R5 had experienced no accidents or injuries. DON stated R5's pain had been intermittent and the only time she had expressed pain was when she had been laying in bed. DON stated they would give R5 Tylenol and get her up and she would be content. DON stated as the pain had not been consistent, she could understand why the nurses on duty had not informed MD-A of R5's pain when MD-A had been at the facility. DON indicated they had been trying to get R5 an appointment due to the change in her condition however, verified there was no documentation of a nursing assessment of the change. DON stated they had been allowing MD-A to make the assessment as that was what MD-A preferred. DON stated they notified MD-A of the change and waited for her to make the assessment. DON verified they notified MD-A of the change on 8/1/18 and R5 was seen on 8/10/18.

On 8/31/18, at 10:28 a.m. MD-A stated she had been a little annoyed R5's right hip pain had not been brought to her attention as she had been in the facility to see R5 twice prior to having been

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notified. MD-A stated it was a strange response to defer the assessment to her and indicated she would not have expected an orthopedic assessment but an RN assessment would have been helpful. MD-A stated she would have like to have known about R5's pain sooner. MD-A stated even though it would not have necessarily have changed her care, as R5 was not a surgical candidate, pain medication may have been needed. MD-A stated the communication should have been better.

--At 10:39 a.m. NA-E stated if a resident had a change she would communicate to the nurse and fill out a "Stop and Watch" form. NA-E indicated these forms were for communicating issues to staff so they would be aware. NA-E indicated the forms were given to the nurses who included the identified concern in report. NA-E provided a Stop and Watch Early Warning Tool which indicated: identified changes while caring for or observing a resident should be circled and the nurse should be notified as soon as possible. The form included areas to document resident name, staff name, reported to with date and time, nurse response with date and time and nurse name. Areas of concern included:
-S: Seems different than usual
-T: Talks or communicates less
-O: Overall needs more help
-P: Pain: new or worsening; participated less in activities
-a: Ate less
-n: No bowel movement in 2 days; or diarrhea
-d: Drank less
-W: Weight change
-A: Agitated
-T: Tired, weak, confused or drowsy
-C: Change in skin color or condition

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F 580	Continued From page 29 -H: Help with walking, transferring, toileting more than usual --At 11:51 a.m. RN-B stated NAs would fill out Stop and Watch forms or communicate any new concerns directly with nurses and indicated the goal was the forms ultimately went to the RN for follow up. RN-B stated if he received information about new pain he would do a head to toe assessment of the resident and then ultimately see if they needed to be seen by a physician. --At 3:41 p.m. RN-C stated if she was notified of a change in a resident, she would assess the resident to see if further action was needed such as notify the physician or implement a nursing order. RN-C indicated most likely there should be something the nurse should be watching and let the MD know it is not clearing up and ask if there is something they would like done. The undated Pain Management Policy directed a comprehensive pain assessment would be completed by a registered nurse on admission, with each MDS assessment thereafter, and when any new pain is identified. The policy indicated pain would be considered the 5th vital sign, checked along with the other 4 standard vital signs (temperature, pulse, respirations and blood pressure). The policy also indicated the physician would be notified of pain levels indicated on the pain evaluation as appropriate. The physician would also be notified when pain persisted or reoccurred despite treatment if suspected adverse consequences were noted. The Notification of Physician/Family on a Condition Change policy dated 9/2017, directed to notify the physician and resident's responsible	F 580		

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F 580	Continued From page 30 party in the event of a status change. The policy directed the physician was to be contacted immediately for any significant change in condition as assessed by a licensed nurse.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		10/17/18

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F 583	Continued From page 31 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff and visitors to view for 3 of 3 residents (R5, R59,R22) observed to have private information posted in their rooms. Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/29/18, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia and stroke. The MDS indicated R5 required extensive assistance with all activities of daily living (ADL). The MDS further indicated R5 exhibited no signs or symptoms of possible swallowing disorder. On 8/29/18, at 2:23 p.m. R5 was observed resting in bed with the lights off, bed in low position and the head of the bed raised approximately 30 degrees. Fall mats were observed on the floor on the door side of the bed and R5 was positioned on her right side. An 8 1/2 x 11 inch sign was posted on wall at head of bed which stated, "thickened liquids, no straws." On 8/30/18, at 7:13 a.m. morning cares were observed for R5. The sign which indicated, "thickened liquids, no straws" remained posted on the wall at the head of the bed. The sign was viewable to anyone who entered R5's room.	F 583	F583: Personal Privacy/Confidentiality of Records R5, R59, and R22 had all confidential information removed or placed in an area not readily available to all residents, staff, and visitors. A facility walk around was completed and any confidential information found in resident□s rooms was removed or placed in an area not readily available to all residents, staff, and visitors by 9/28/18. The facility□s Dignity policy that includes privacy issues was revised to include: Private or personal care instructions will not be posted in an area that is readily available for other residents, staff and visitors to view. If the resident requests personal information to be posted, this will be care planned. Nursing staff were educated on the revised Dignity policy regarding posting of confidential resident information on 10/9/18 and 10/12/18. A letter was sent out to the families to educate them on the resident□s right to privacy and not posting personal care instructions on the walls in sight of other residents, families and visitors by 10/5/18. The Director of Nursing/designee will randomly audit rooms for noncompliance 2X week for 4 weeks, weekly x 4 weeks, then monthly thereafter. Audits results will be brought to the QAPI Committee for review and further recommendations.	

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R59's quarterly MDS dated 5/22/18, indicated R59 had moderate cognitive impairment and diagnoses which included cerebral aneurysm, seizure disorder and depression. The MDS indicated R59 required extensive to total assistance with ADLs. The MDS also indicated R59 had a feeding tube and received 51% or more of total calories through parenteral or tube feeding

R59's undated Care Plan reviewed 5/31/18, identified R59 had a PEG (percutaneous endoscopic gastrostomy) tube (a tube surgically placed through the abdominal wall into the stomach) and directed staff to implement interventions which included but were not limited to:
--check that the tubing remained in the correct location
--elevate head of bed to 30 degrees
--position consistent with R59's individual needs

On 8/29/18, at 2:17 p.m. R59 was observed resting in bed with the head of bed raised. An 8 1/2 x 11 inch sign was observed posted on the wall by the head of R59's bed which indicated, "Must have head of bed up at 45 degrees at all times, NAR's [nursing assistants] please make sure feeding tube is not under her when you reposition resident. Nurses please clamp off tube feeding when not in use." The sign was visible from the doorway to R59's room.

On 8/30/18, at 7:54 a.m. an 8 1/2 x 11 inch sign was observed posted on the outside of R59's room door. The sign indicated, "HOB [head of bed] must be elevated 45 degrees at all times." R59's room door was shut and the sign was visible in the common corridor.

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--At 11:18 a.m. the signs remained posted to the wall in R59's room and on the door.

On 8/31/18, at 9:51 a.m. the signs remained posted.

--at 2:42 p.m. nursing assistant (NA)-B stated they had the signs up in residents' rooms to give staff a reminder to make sure the directions were followed. NA-C verified residents have a right to privacy and confirmed the signs did not honor that right.

--At 4:22 p.m. registered nurse (RN)-A verified signs posted with personal care information was a privacy issue and the signs should not have been posted.

R22's annual MDS dated 4/5/18, indicated diagnoses that included, but were not limited to: hemiparesis/hemiplegia, and cerebrovascular accident (stroke). The MDS indicated R22 was cognitively impaired, and was totally dependent on one staff for grooming activities.

On 8/27/18, at 7:05 p.m. 8/28/18, at 3:30 p.m. 8/29/18, at 10:09 a.m. and 8/30/18, at 8:53 a.m. it was noted that R22 had multiple signs posted on the bedroom walls and doors which included personal care instructions. The signs were posted with the following information:

-Strongly encourage participation in activities.

-Make sure [R22] has call light within reach AT ALL TIMES.

-Please make sure his ROHO cushion from his

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recliner goes under him when he is upright in the wheelchair. The blue sheet remains under the cushion. Roho- dycem-cushion. Important!

-Stay in room during Neb treatment. He pulls off the mask sometimes. THANKS!

-PLEASE MAKE SURE HEAD OF BED IS ELEVATED 30-45 DEGREES AT ALL TIMES. THANKS!

-Place glasses by the TV when not in use.

On 8/27/18, at 7:05 p.m. the daughter of R22 family member (FM)-A was interviewed during which she stated that she and her sister FM-B hung all of the aforementioned signs on R22's walls because there was a large amount of staff turn over and they were frustrated with finding their father's care to be compromised because the staff didn't know how to care for their father. When asked if the signs helped the situation, FM-A stated, "not really." FM-A was asked if she or her sister FM-B had been educated regarding R22's right to privacy and not posting personal care instruction's on the walls and FM-A stated, "no." FM-A did confirm that R22 did occasionally have visitors that were not family members.

On 8/31/18, at 10:30 a.m. the director of nursing (DON) was interviewed and stated that the family members of R22 were responsible for making and posting the signs in R22's room which detailed private personal care instructions. The DON confirmed the information was personal care information and all visitors did not need access to that information. The DON stated the facility could find an alternative method of sharing care information with the staff.

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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F 583	Continued From page 35 A policy regarding resident privacy was requested but not received.	F 583		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than	F 609	F609: TRCC□s goal is to report to the state, no later than two hours, of any	10/17/18

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F 609	Continued From page 36 two hours, to the administrator and state agency (SA), an injury of unknown origin with a serious bodily injury for 1 of 1 resident (R5) who experienced a hip fracture, and an incident of abuse for 1 of 1 resident (R25) who experienced resident to resident abuse. In addition, failed to report misappropriation of resident property for 1 of 1 resident (R50) who reported missing money and personal property. Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/29/18, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, anxiety disorder, psychosis and pain. The MDS indicated R5 required extensive assistance with activities of daily living (ADL), and was non-ambulatory. The MDS further indicated R5 experienced no pain at the time of the assessment and had not received scheduled or as needed (PRN) pain medication. R5's Pain Care Area Assessment (CAA) dated 8/21/18, indicated R5 had no noticeable signs of pain noted, no facial grimacing, moaning, calling out or restlessness. R5 denied pain upon interview. The CAA indicated R5 had been diagnosed with a right hip fracture on 8/10/18, for which the physician prescribed Tramadol 50 milligrams (mg) three times daily PRN which she had received twice, along with extra strength Tylenol 1000 mg scheduled three times daily. The Care Plan was updated 8/10/18, to indicate R5 had decreased mobility related to a non-surgical fracture of the right femur head and directed staff to assist as needed with mobility.	F 609	alleged violations of maltreatment. R5 had a VA report filed on 9/4/18. R25, had a late VA report on 8/1/18. R50 had VA report filed during survey, on 8/30/18. All Care Center staff will be re-educated on reporting requirements according to the facility□s policies on Maltreatment and Reporting Guidelines by 10/12/18. DON/designee will audit progress notes for any potentially reportable incidents on a daily basis. Social Services/designee will audit concern forms for any potentially reportable incidents daily X 2 weeks, 3 X week X 2 weeks, then weekly thereafter. Audit results will be brought to the QAPI Committee quarterly for review and further recommendations.	

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F 609	Continued From page 37	F 609		

Review of R5's medical record revealed the following events:
--7/16/18, progress note: transferred to emergency room at 10:30 p.m. for evaluation.
--7/16/18 to 7/17/18, ED [emergency department] note: diagnosed with urinary tract infection and prescribed antibiotic. Lab order identified urine collection was via straight catheter.
--7/17/18, Urgent Care Note: transferred to urgent care at 12:30 p.m. for fatigue, somnolence and elevated blood sugar.
--7/17/18, Progress Notes: returned to facility at 3:37 p.m. and then complained of left leg pain at 6:46 p.m. R5 also had a fever of 100.8 and was given Tylenol.
--7/19/18, Progress Note: R5 complained of continuous right hip pain with gradual onset. R5 hollered and moaned with movement and was given two Tylenol.
--7/21/18, Progress Note: R5 developed a fluid filled blister to the right heel and the physician (MD) was notified via fax.
--7/21/18, MD in to the facility to see R5's right heel blister and recommended referral to Podiatry. MD was not notified of new onset of pain and right hip pain was not addressed.
--7/26/18, Progress Note: received orders from Podiatrist for right heel ulcer.
--7/30/18, Nursing Home Note: R5 seen by MD for routine visit. MD was not notified of right hip pain and pain was not addressed.
--8/1/18, Nurse Communication to Physician order: Situation/Background: R5 has been having right hip pain on and off for approximately 2 week. No injury. Unable to schedule appointment with you for 2 weeks. Would you like her to be seen in urgent care or can you fit her in? Physician/Provider Response: MD-A indicated: Please remind staff that this should be

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F 609	Continued From page 38	F 609		

mentioned when I round. I saw her twice during the last couple weeks and this was not mentioned. I have openings next week or she can be seen in same day care.
--8/1/18, Progress note: R5 continued to complain of right hip pain with no injury. Appointment scheduled for 8/3/18. Notified daughter, she is unable to attend.
--8/8/18, Progress note: She has been having right hip pain and has been receiving PRN Tylenol for pain control. Spoke with daughter about keeping her scheduled appointment for 8/14/18, or being seen sooner. She agreed she could be seen in Same Day Care on 8/10/18, and she will meet at the clinic.

R5's Office Visit note dated 8/10/18, indicated R5 had been having problems with pain in her hip. Nobody was quite sure when it had begun. R5 complained of pain to right hip with movement but had no pain when not moved. X-rays were reviewed and R5 was noted to have osteopenia (condition in which bone mineral density is lower than normal) present and was noted to have a subcapital displaced femoral neck (extending through the junction of the head and neck of femur) fracture. The fracture margins were rounded and smoothed, suggestive that several weeks had passed since R5's fracture occurred. The physician's impression was subacute to possible chronic femoral neck fracture of right hip. The recommendation was non-surgical treatment.

On 8/30/18, at 2:06 p.m. registered nurse (RN)-A confirmed R5 had an emergency room (ER) visit on 7/17/18, for a urinary tract infection and also had been seen in urgent care for high blood pressure on that date. RN-A confirmed R5 had

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F 609	Continued From page 39	F 609		

complained of leg pain on 7/17/18, and had first complained of right hip pain on 7/19/18. RN-A indicated they had been able to get an earlier appointment and R5 was seen on 8/10/18. RN-A indicated there was no documentation of an injury or accident for R5.

--at 2:51 p.m. the director of nursing (DON) verified R5 had been diagnosed with a hip fracture on 8/10/18. DON confirmed R5 had experienced no accidents or injuries. DON stated they had discussed injury of unknown origin related to R5's hip fracture. DON indicated they determined R5 had no pain prior to leaving the facility on 7/16/18, and when they received the diagnosis, they attributed it to the hospital transfer and had not investigated further. DON stated they had no reason to believe anything else had occurred due to the timeline of events. DON confirmed she had not contacted the hospital and had not considered reporting the incident to the state agency related to injury of unknown origin once they were aware of the fracture (serious bodily injury).

The Skilled Nursing Facility Maltreatment Reporting Guidelines dated 5/17/18, directed an event or allegation that involves abuse or results in serious bodily injury must be reported immediately (immediately is no later than 2 hours after the event or allegation has occurred).

R25's quarterly MDS dated 7/3/18, indicated R25 had severe cognitive impairment and had diagnoses which included dementia, anxiety disorder, and depression.

The facility submitted an Incident Report to the

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Office of Health Facility Complaints (OHFC) on 8/1/18, which indicated on 8/1/18, during a review of R117's medical record it was noted on 7/28/18, at 1:30 p.m. R25 had been struck on shoulder and grabbed by her wrist by R117, while in the dining room. The report indicated staff had not notified administration or reported the incident to the SA. Management reported to SA after reviewing charts and discovery incident had occurred on 8/1/18, four days later. R25 was interviewed twice by two staff members. During the first interview R25 recalled what happened and stated she was scared. During the second interview, R25 had no recollection of the event and denied further concerns or issues. Staff education was provided to all members involved and disciplinary action for the nurse present during the incident was implemented. R117 was transferred to a behavioral health unit for further medical management.

On 8/30/18, at 3:25 p.m. the DON verified the resident to resident abuse had not been reported to administrator or SA as required. DON stated they had identified the situation and corrected it at the time. DON indicated they had disciplined the staff involved and reeducated the remaining staff. DON stated they reported the incident to the SA late and received disposition.

R50's Admission Record dated 8/31/18, indicated R50's diagnoses included chronic pain, and major depressive disorder.

R50's quarterly MDS dated 7/31/18, indicated R50 had no cognitive impairment, did not have

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F 609	Continued From page 41	F 609		

indicators of delirium or delusions, had no mood symptoms, and had no inappropriate behavior. The MDS indicated R50 used verbal communication appropriately, was easily understood and was able to fully understand others during communication.

R50 was interviewed on 8/28/18, 12:40 p.m. and stated approximately a month prior another resident (R24) come into his room and stole some war memorabilia (pens that looked like bullets) and $20.00 out of the top drawer of the bedside stand. R50 stated that he reported the theft to the social services designee, but was not sure if an investigation had been completed. R50 stated that he did not know if the theft had been reported to law enforcement.

The social service designee (SSD) was interviewed on 8/29/18, at 1:20 p.m. during which she confirmed that R50 had reported that he thought he had some money missing but was not sure, and she was unaware of the missing pens that looked like bullets. The SSD stated she had not completed an internal investigation and reported the incident to the administrator and state agency because R50 stated he could not be sure if the money was actually missing. The SSD stated R50 reported that he thought R24 had stolen the money. The SSD confirmed that R24 had a known history of taking items not belonging to her. The SSD was asked to provide documentation of R50's report of possible missing money and the SSD provided a Concern Report dated 8/7/18, which indicated R50 had reported to the SSD that he may have had some money missing but was unsure if it was missing or not and was unsure of the amount. There was no investigation documented on the Concern

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F 609	Continued From page 42 Report, however, R50 was given a key to lock up valuables, and educated on keeping money safe by placing it in the resident trust account in the facilities office. The follow-up section of the Concern Report indicated that this incident was not reported due to no allegations of theft. R50's progress notes from 8/1/18 - 8/29/18 were reviewed and there was no documentation which indicated R50's report to the SSD of possible theft of money and memorabilia had not been reported to the facility administrator or the state agency. Review of the Skilled Nursing Facility Maltreatment Reporting Guidelines dated as last amended on 5/17/18, indicated if financial exploitation was suspected, the incident should be immediately reported to the administrator and within two hours an online report would be made to the Office of Health Facility Complaints (OHFC). Report alleged theft to local law enforcement. Report alleged financial exploitation to the Adult Protection Agency. The Social Service Designee was again interviewed on 8/29/18, at 2:30 p.m. during which she confirmed that the administrator and OHFC had not been notified of R50's report of possible missing money and memorabilia on 8/7/18, according to the facility policy. The SSD confirmed she was new to the role of SSD and being responsible had little training related to reporting allegations.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		10/17/18

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F 610	Continued From page 43 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigation for all injuries of unknown origin with serious bodily injury for 1 of 1 resident (R5) who experienced a hip fracture, and an incident of abuse for 1 of 1 resident (R25) who experienced resident to resident abuse. In addition, failed to investigate financial exploitation for 1 of 1 resident (R50) who reported missing money and personal property. Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/29/18, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, anxiety disorder, psychosis and pain. The MDS indicated R5 required extensive assistance with activities of daily living (ADL), and was non-ambulatory. The	F 610	F610: TRCC conducts a thorough investigation in response to any allegations of abuse, neglect, or mistreatment. R5 had an investigation completed after report made to the state, and the disposition came back on 9/9/18. R25 had an investigation following the report to the State and the disposition came back on 8/6/18, and R50 had an investigation with corrective actions placed during survey following the report to the State, and the disposition came back on 9/17/18. All Care Center staff will be re-educated on investigation requirements according to the facility□s policies on Maltreatment by 10/12/18. The Administrator/designee will audit VA reports for investigation and corrective	

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F 610	Continued From page 44 MDS further indicated R5 experienced no pain at the time of the assessment and had not received scheduled or as needed (PRN) pain medication. R5's Pain Care Area Assessment (CAA) dated 8/21/18, indicated R5 had no noticeable signs of pain noted, no facial grimacing, moaning, calling out or restlessness. R5 denied pain upon interview. The CAA indicated R5 had been diagnosed with a right hip fracture on 8/10/18, for which the physician prescribed Tramadol 50 milligrams (mg) three times daily PRN which she had received twice, along with extra strength Tylenol 1000 mg scheduled three times daily. The Care Plan was updated 8/10/18, to indicate R5 had decreased mobility related to a non-surgical fracture of the right femur head and directed staff to assist as needed with mobility. Review of R5's medical record revealed the following events: --7/16/18, progress note: transferred to emergency room at 10:30 p.m. for evaluation. --7/16/18 to 7/17/18, ED [emergency department] note: diagnosed with urinary tract infection and prescribed antibiotic. Lab order identified urine collection was via straight catheter. --7/17/18, Urgent Care Note: transferred to urgent care at 12:30 p.m. for fatigue, somnolence and elevated blood sugar. --7/17/18, Progress Notes: returned to facility at 3:37 p.m. and then complained of left leg pain at 6:46 p.m. R5 also had a fever of 100.8 and was given Tylenol. --7/19/18, Progress Note: R5 complained of continuous right hip pain with gradual onset. R5 hollered and moaned with movement and was given two Tylenol.	F 610	actions taken, weekly X 6 weeks then monthly thereafter. Audit results will be brought to the QAPI Committee quarterly for review and further recommendations.	

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--7/21/18, Progress Note: R5 developed a fluid filled blister to the right heel and the physician (MD) was notified via fax.
--7/21/18, MD in to the facility to see R5's right heel blister and recommended referral to Podiatry. MD was not notified of new onset of pain and right hip pain was not addressed.
--7/26/18, Progress Note: received orders from Podiatrist for right heel ulcer.
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--8/1/18, Progress note: R5 continued to complain of right hip pain with no injury. Appointment scheduled for 8/3/18. Notified daughter, she is unable to attend.
--8/8/18, Progress note: She has been having right hip pain and has been receiving PRN Tylenol for pain control. Spoke with daughter about keeping her scheduled appointment for 8/14/18, or being seen sooner. She agreed she could be seen in Same Day Care on 8/10/18, and she will meet at the clinic.

R5's Office Visit note dated 8/10/18, indicated R5 had been having problems with pain in her hip. Nobody was quite sure when it had begun. R5

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complained of pain to right hip with movement but had no pain when not moved. X-rays were reviewed and R5 was noted to have osteopenia (condition in which bone mineral density is lower than normal) present and was noted to have a subcapital displaced femoral neck (extending through the junction of the head and neck of femur) fracture. The fracture margins were rounded and smoothed, suggestive that several weeks had passed since R5's fracture occurred. The physician's impression was subacute to possible chronic femoral neck fracture of right hip. The recommendation was non-surgical treatment.

On 8/30/18, at 2:06 p.m. registered nurse (RN)-A confirmed R5 had an emergency room (ER) visit on 7/17/18, for a urinary tract infection and also had been seen in urgent care for high blood pressure on that date. RN-A confirmed R5 had complained of leg pain on 7/17/18, and had first complained of right hip pain on 7/19/18. RN-A indicated they had been able to get an earlier appointment and R5 was seen on 8/10/18. RN-A indicated there was no documentation of an injury or accident for R5.

--at 2:51 p.m. the director of nursing (DON) verified R5 had been diagnosed with a hip fracture on 8/10/18. DON confirmed R5 had experienced no accidents or injuries. DON stated they had discussed injury of unknown origin related to R5's hip fracture. DON indicated they also discussed this with R5's daughter who felt R5's pain had not started until after the transfer to the ambulance on 7/16/18. DON stated due to the discussion with R5's daughter, they determined the fracture potentially happened during transfer to the hospital as R5 had

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undergone multiple physical transfers: bed to gurney, gurney to ambulance, ambulance to hospital, gurney to bed, and also transfers for a CT scan procedure. DON indicated when R5's daughter notified her of R5's diagnosis of hip fracture she had contacted the facility consultant and discussed the situation. DON indicated they determined R5 had no pain prior to leaving the facility and when they received the diagnosis, they attributed it to the hospital transfer and had not investigated further. DON stated they had no reason to believe anything else had occurred due to the timeline of events. DON verified R5 had undergone a straight catheterization procedure at the hospital and stated she never thought of that as a potential contributing factor. DON confirmed she had not contacted the hospital and had not considered reporting the incident to the state agency related to potential abuse occurring at the hospital.

R25's quarterly MDS dated 7/3/18, indicated R25 had severe cognitive impairment and had diagnoses which included dementia, anxiety disorder, and depression.

The facility submitted an Incident Report to the Office of Health Facility Complaints (OHFC) on 8/1/18, which indicated on 8/1/18, during a review of R117's medical record it was noted on 7/28/18, at 1:30 p.m. R25 had been struck on shoulder and grabbed by her wrist by R117, while in the dining room. The report indicated staff had not notified administration or reported the incident to the SA. Management reported to SA after reviewing charts and discovery incident had occurred on 8/1/18, four days later. R25 was interviewed twice by two staff members. During

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the first interview R25 recalled what happened and stated she was scared. During the second interview, R25 had no recollection of the event and denied further concerns or issues. Staff education was provided to all members involved and disciplinary action for the nurse present during the incident was implemented. R117 was transferred to a behavioral health unit for further medical management.

On 8/30/18, at 3:25 p.m. the DON verified the resident to resident abuse had not been reported to administrator or SA as required. DON stated they had identified the situation and corrected it at the time. DON indicated they had disciplined the staff involved and reeducated the remaining staff. DON stated they reported the incident to the SA late and received disposition.

R50's Admission Record dated 8/31/18, indicated R50's diagnoses included chronic pain, and major depressive disorder.

R50's quarterly MDS dated 7/31/18, indicated R50 had no cognitive impairment, did not have indicators of delirium or delusions, had no mood symptoms, and had no inappropriate behavior. The MDS indicated R50 used verbal communication appropriately, was easily understood and was able to fully understand others during communication.

R50 was interviewed on 8/28/18, 12:40 p.m. and stated approximately a month prior another resident (R24) come into his room and stole some war memorabilia (pens that looked like bullets) and $20.00 out of the top drawer of the

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bedside stand. R50 stated that he reported the theft to the social services designee, but was not sure if an investigation had been completed. R50 stated that he did not know if the theft had been reported to law enforcement.

The social service designee (SSD) was interviewed on 8/29/18, at 1:20 p.m. during which she confirmed that R50 had reported that he thought he had some money missing but was not sure, and she was unaware of the missing pens that looked like bullets. The SSD stated she had not completed an internal investigation and reported the incident to the administrator and state agency because R50 stated he could not be sure if the money was actually missing. The SSD stated R50 reported that he thought R24 had stolen the money. The SSD confirmed that R24 had a known history of taking items not belonging to her. The SSD was asked to provide documentation of R50's report of possible missing money and the SSD provided a Concern Report dated 8/7/18, which indicated R50 had reported to the SSD that he may have had some money missing but was unsure if it was missing or not and was unsure of the amount. There was no investigation documented on the Concern Report, however, R50 was given a key to lock up valuables, and educated on keeping money safe by placing it in the resident trust account in the facilities office. The follow-up section of the Concern Report indicated that this incident was not reported due to no allegations of theft.

R50's progress notes from 8/1/18 - 8/29/18 were reviewed and there was no documentation which indicated R50's report to the SSD of possible theft of money and memorabilia had not been reported to the facility administrator or the state

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F 610	Continued From page 50 agency. Review of the Skilled Nursing Facility Maltreatment Reporting Guidelines dated as last amended on 5/17/18, indicated if financial exploitation was suspected, the incident should be immediately reported to the administrator and within two hours an online report would be made to the Office of Health Facility Complaints (OHFC). Report alleged theft to local law enforcement. Report alleged financial exploitation to the Adult Protection Agency. The Social Service Designee was further interviewed on 8/29/18, at 2:30 p.m. during which she confirmed she had not completed an internal investigation regarding R50's complaint of missing money because R50 stated he was unsure. The SSD agreed that an internal investigation could have determined if R50 truly had missing money. The SNF [Skilled Nursing Facility] Maltreatment Investigation & Reporting policy dated 1/30/16, indicated all incidents of unknown origin would be investigated. The policy directed an initial investigation must be conducted immediately to determine what happened and whether the incident requires reporting to the SA.	F 610		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		10/17/18

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F 677	Continued From page 51 Based on observation, interview and document review, the facility failed to ensure routine grooming related to oral care, removal of facial hair, and/or hearing aide hygiene for 2 of 2 residents (R22, R51) who were observed during personal cares and assessed to be dependent or required extensive staff assitance for grooming needs. Findings include: R22's annual Minimum Data Set (MDS) dated 4/5/18, indicated R22's diagnoses included hemiparesis/hemiplegia (one sided weakness/paralysis), and cerebrovascular accident (stroke). The MDS indicated R22 was totally dependent on one staff for grooming activities. R22's care plan for grooming dated 6/12/14, directed the staff to assist R22 with brushing teeth and dentures twice and day and to assist/provide as necessary daily shaving or every other day. The care plan for communication directed the staff to assist with putting in and taking the hearing aides out, and to check to ensure the hearing aides are working properly. On 8/27/18, at 7:05 p.m. family member (FM)-A was interviewed and stated when her father lived at home he shaved daily without exception, and also brushed his teeth at least daily if not twice daily. FM-A observed R22 and stated it did not look like her father had been shaved for a few days. FM-A stated that in the last three months she had reported to the nurse manager and some of the front line staff she was unhappy that her father had not been shaved daily. FM-A stated she had even purchased a new electric razor for	F 677	F677: TRCC provides ADL care for residents who require staff assistance, R22- Care Plan has been updated to show his refusals are due to his long term NPO status, he frequently gags and chokes when he/she has that swallowing reflex. Oral cares will now be completed by the LPN/RN after they administer his BID nebulizer treatments. Hearing aids will now be checked by LPN/RN while they are completing his oral cares. They will clean the HA as well as make sure they are functioning appropriately. The shaving care plan has been updated on the NAR caregiver sheets to provide further education regarding his wishes on grooming. R51 - Involved NARs were educated in regards to following policy/procedure. NAR responsible for Oral cares should be the one that assisted resident up and provided the denture care. All NAR staff were re-educated on providing cares according to a resident□s individualized care plan on 10/9/18 and 10/12/18. Random audits (observation) of AM cares will be conducted by DON/designee 3 X week X 4 weeks, then weekly X 4 weeks and monthly thereafter, to ensure ADL assistance is being provided adequately for oral cares, shaving and HA placement, with positive or corrective feedback upon completion of the observation. Audit results will be brought to QAPI Committee for review and further recommendations.	

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staff to use when shaving R22, but the staff still had not used it rather used a single use disposable razor and shaving cream, and her father had not been assisted with shaving daily, as requested. Additionally, FM-A stated her father had purchased new hearing aides a few months ago and they were worn 24 hours a day. FM-A proceeded to remove one of the hearing aides from R22's ear which was noted to have a large amount of yellow wax build up and white flakes of sloughed skin on the portion that fit into the ear. FM-A stated she had repeatedly complained to the facility staff that the hearing aides were not cleaned daily and checked to ensure they were functioning. FM-A stated generally she or her sister (FM-B) had to make sure the hearing aides are cleaned and functioning during their daily visits.

On 8/29/18, at 10:09 a.m. R22 was observed to receive morning cares. Nursing assistant (NA)-E and NA-F provided the cares, however, the NAs did not assist R22 with shaving or oral cares. R22 was observed to have his hearing aides in, however, the NAs were not observed to ensure they were clean or functional.

-At 10:14 a.m. NA-E confirmed she had not provided R22 assistance with shaving and oral care and thought R22 was only assisted with shaving on bath days. NA-E also stated R22 had a history of gagging when putting in the dentures and choking on the toothpaste and water used during oral care when brushing R22's natural teeth therefore, she did not feel comfortable providing R22 oral care. NA-E stated she had notified the nurse manager assigned to R22's care that R22 gagged on his dentures and choked on the toothpaste and water when

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attempting oral care but had not been informed a different plan for oral care had been developed. NA-E stated she was not aware if she needed to clean R22's hearing aides or ensure they were functioning.

On 8/30/18, at 4:07 p.m. FM-B confirmed she wanted R22 to be shaved daily and was assisted with oral care at least one time a day as per R22's customary routine prior to entering the nursing home.

On 8/31/18, at 10:31 a.m. the director of nursing (DON) confirmed R22 should have been offered assistance with shaving and oral care at least daily or according to the written care plan. The DON also stated R22's hearing aides should have been cleaned and ensured they were functioning properly. The DON stated implementing a resident's care plan was a standard of practice.

The Oral Hygiene policy revised 2/2016, indicated the purpose of oral hygiene was to provide cleanliness of mouth and teeth:

1. Cleanse and irrigate tooth surfaces and stimulate gums and mucosa.
2. Prevent infection and dental caries
3. Promote self-esteem and comfort.
4. Maintain resident's appetite and nutrition
5. Develop resident understanding of importance of oral hygiene and skills in performing teeth brushing.

The policy directed oral cares should be done at least BID [twice daily] for residents, and more frequently as determined by assessment or request.

A policy related to shaving and hearing aide care

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was requested and none was provided.
R51's Face Sheet dated 8/30/18, indicated R51 had diagnoses which included dementia without behavioral disturbance, panlobular emphysema (progressive disease of the lungs) and macular degeneration (medical condition which may result in blurred or no vision in the center of the visual field).

R51's quarterly Minimum Data Set (MDS) dated 7/31/18, indicated R51 had severe cognitive impairment and required extensive assistance of one staff for all activities of daily living (ADL) including personal hygiene.

R51's care plan reviewed on 5/18/18, indicated R51 required assistance with grooming and personal hygiene. The plan also indicated R51 had dentures or partials and directed staff to offer mouth rinse/wash with AM and HS [bedtime] cares.

On 8/27/18 at 6:08 p.m. R51 was observed to have a thick coating of a white substance around the base of her lower natural teeth.

On 8/29/18, at 7:26 a.m. nursing assistant (NA)-A was observed to enter R51's room, greet and assist R51 to transfer to a wheelchair. NA-A stated R51 was having a bath and assisted R51 to donn a bathrobe. NA-A wheeled R51 to the bathroom and assisted R51 to stand, pivot and sit on the toilet. NA-A removed R51's wet incontinent brief and placed a clean one on. While seated on the toilet, NA-A applied R51's glasses and combed her hair. NA-A brushed R51's upper denture plate and gave the plate to R51 who inserted it into her mouth. NA-A assisted R51 to stand, provided perineal care, raised her brief and

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assisted her to sit in the wheelchair. No infection control concerns were identified during the observation. NA-A wheeled R51 into the hall, retrieved a portable oxygen concentrator, attached it to the back of R51's wheelchair, placed the nasal cannula in her nose, and wheeled R51 to the dining room. At no time was NA-A observed to encourage or assist R51 to brush her lower natural teeth.

--At 9:41 a.m. R51 was observed awake and resting in bed. R51's bottom teeth were noted to have a thick coating of a white substance along the base of her lower teeth.

--At 11:23 a.m. NA-A confirmed she had not offered or assisted R51 to brush her teeth. NA-A indicated the bath aid would have done this after her bath.

--At 11:24 AM NA-B confirmed she had given R51 her bath. NA-B stated she had not assisted R51 to brush her teeth and indicated this was usually done by the aid who got her up in the morning.

On 8/30/18, at 3:09 p.m. the director of nursing verified staff should have provided R51 oral cares during morning cares.

The Oral Hygiene policy revised 2/2016, indicated the purpose of oral hygiene was to provide cleanliness of mouth and teeth:

1. Cleanse and irrigate tooth surfaces and stimulate gums and mucosa.
2. Prevent infection and dental caries
3. Promote self-esteem and comfort.
4. Maintain resident's appetite and nutrition

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F 677	Continued From page 56 5. Develop resident understanding of importance of oral hygiene and skills in performing teeth brushing. The policy directed oral cares should be done at least BID [twice daily] for residents, and more frequently as determined by assessment or request.	F 677		
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 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 comprehensively assess a change in condition related to increased verbal and non-verbal expressions of severe pain and behaviors in order to determine the need for timely intervention and treatment for 1 of 1 resident (R5) who sustained an unexplained hip fracture. This resulted in actual harm for R5 whose treatment of her hip fracture was delayed for 22 days and had moderate to severe pain as a result of the fracture. Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/29/18, indicated R5 had severe cognitive impairment and diagnoses which included	F 684	F684: It is TRCC□s goal to identify verbal and nonverbal symptoms of pain in order to provide adequate pain control when needed. R5 had a Comprehensive Pain Assessment completed that included a review of the resident□s previous pain symptoms to determine how reporting this to the MD could have gotten missed when the MD visited. An audit of all residents with identified moderate to severe pain will be conducted to ensure they are receiving adequate pain relief. Education was provided for nursing staff on the facility□s Pain policy and process for checking and following up on pain on	10/17/18

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F 684	Continued From page 57 Alzheimer's disease, dementia, anxiety disorder, psychosis and pain. The MDS indicated R5 required extensive assistance with activities of daily living (ADL), was non-ambulatory, and had no functional limitations in range of motion of her upper or lower extremities. The MDS further indicated R5 experienced no pain at the time of the assessment and had not received scheduled or as needed (PRN) pain medication. R5's Pain Care Area Assessment (CAA) dated 8/21/18, indicated R5 had no noticeable signs of pain noted no facial grimacing, moaning, calling out or restlessness. R5 denied pain upon interview. The CAA indicated R5 had been diagnosed with a right hip fracture on 8/10/18, for which the physician prescribed Tramadol (narcotic like pain reliever to treat moderate to severe pain) 50 milligrams (mg) three times daily PRN which she had received twice, along with extra strength Tylenol 1000 mg scheduled three times daily. Staff stated R5 sometimes complained of pain when repositioned or during dressing changes to her right heel. Staff also indicated R5 had no complaints of pain when seated in a Geri chair (large padded chair with wheeled base). Non-pharmacological interventions for pain included: warm/cool pack and repositioning. Goal for pain management was not to have pain which had been met and R5 was able to enjoy activities. R5's Care Plan reviewed 6/13/18, indicated R5 was able to express her needs and occasionally expressed pain. The Care Plan directed staff to provide medications as ordered and observe for signs and symptoms of discomfort and treat and update provider as necessary. The Care Plan also indicated R5 was at risk for fall or injury	F 684	10/1/18. Random audits of residents exhibiting moderate to severe pain will be conducted 2X week X 4, then weekly x 4 and monthly thereafter, to ensure the Physician is notified and appropriate measures are taken to provide adequate pain relief. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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related to cognitive deficits and directed staff to provide pain assessment and monitoring. The Care Plan further indicated R5 had behaviors which included calling out/disruptive noises, spitting out medications and refusing cares. The Care Plan directed staff to implement interventions which included:
--ask if there was anything needed/reason for calling out/disruptive noises
--attempt to meet R5's needs when calling out/disruptive noises
--monitor frequency of calling out/disruptive noises
--report all behaviors to the nurse to chart
--update physician as needed for behavior changes.

The Care Plan was updated 8/10/18, to indicate R5 had decreased mobility related to a non-surgical fracture of the right femur head and directed staff to assist as needed with mobility.

On 8/29/18, at 8:34 a.m. R5 was observed dressed and seated in a Geri chair in the dining room for breakfast. Staff observed to ask preferences for breakfast meal. R5 exhibited no verbal or non-verbal indicators of pain.
--At 12:11 p.m. R5 was seated in a Geri chair in dining room eating the noon meal with assistance from nursing assistant (NA)-L. R5 exhibited no verbal or non-verbal indicators of pain.
--At 2:23 p.m. R5 was observed resting in bed with the lights off. R5 was positioned on her right side. No verbal or non-verbal indicators of pain observed.

On 8/30/18, at 7:11 a.m. R5 was observed resting quietly in bed, positioned on her left side.
--At 7:13 a.m. NA-M entered R5's room and

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greeted R5. NA-M checked R5's incontinent brief, then assisted R5 to roll onto her back and NA-M lowered her pants and removed the brief. NA-M provided perineal care and provided cues and assistance for R5 to roll back again after assisting R5 to don a clean brief. Registered Nurse (RN)-A entered the room with mechanical lift and RN-A and NA-M transferred R5 to the Geri chair with the use of the lift. NA-M wheeled R5 into the bathroom, set up and provided cues for R5 to brush her teeth, comb her hair and wash her hands. R5 tolerated the cares and transfer well and did not express verbal or non-verbal signs of pain.

Review of R5's medical record revealed the following events and progression of verbal and non-verbal expressions of pain exhibited by R5:
--7/16/18, progress note (PN): R5 transferred to emergency room (ER) at 10:30 p.m. for evaluation.
--7/16/18, -7/17/18, ED [emergency department] note: diagnosed with urinary tract infection and prescribed antibiotic. Lab order identified urine collection was via straight catheter.
--7/17/18, PN at 2:37 a.m. returned from ER at 1:10 a.m..
--7/17/18, PN at 7:52 a.m. Fax communication sent to primary care physician (PCP) updating that R5 was sent to ER last evening returned diagnosis of urinary tract infection (UTI).
--7/17/18, PN at 2:15 p.m. transferred to urgent care at approximately 12:30 p.m..
--7/17/18, Urgent Care Note: transferred to urgent care at 12:30 p.m. for fatigue, somnolence and elevated blood sugar.
--7/17/18, PN at 3:37 p.m. returned to facility from ER visit. New orders continue Cipro (antibiotic) 500 mg twice daily for 7 days. Novolog

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(insulin) subcutaneous sliding scale, BMP [basic metabolic panel] (laboratory testing) and CBC [complete blood count] (laboratory testing) June [sic] 20th, 2018. Will update primary healthcare provider.
--7/17/18, PN at 6:46 p.m. Resident has been complaining of left leg pain. R5 also had a fever of 100.8 and was given Tylenol.
--7/19/18, at 2:03 p.m. PN: R5 complained of continuous right hip pain with gradual onset which has affected mobility. R5 hollered and moaned with movement and was given two Tylenol.
--7/19/18, PN at 8:59 p.m. pain control unrelieved by medication.
--7/19/18, PN at 9:00 p.m. resident verbalized knee pain.
--7/20/18, at 12:19 p.m. PN: verbalized hip pain.
--7/21/18, PN at 7:54 a.m. R5 developed a fluid filled blister to the right heel and the physician (MD) was notified via fax.
--7/21/18, PN at 1:50 p.m. MD in to the facility to see R5's right heel blister and recommended referral to Podiatry. MD was not notified of new onset of pain and right hip pain was not addressed.
--7/22/18, PN at 4:25 p.m. verbalized hip pain, repositioned for comfort.
--7/24/18, PN at 1:18 p.m. hip pain rated 9/10 (0 being no pain at all and 10 being the worst pain), screaming, moaning.
--7/25/18, PN at 1:23 p.m. hip pain rated 6/10, screaming, grimacing, and moaning.
--7/25/18, PN at 9:39 p.m. verbalized acute hip/leg pain rated 8/10.
--7/26/18, PN at 3:53 p.m. received orders from Podiatrist for right heel ulcer.
--7/27/18, PN at 6:49 p.m. back pain rated 5/10, unrelieved at 9:43 p.m..
--7/30/18, PN at 12:43 p.m. verbalized acute back

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F 684	Continued From page 61 pain/ache rated 6/10. --7/30/18, Nursing Home Note: R5 seen by MD for routine visit. (However, MD was not notified of right hip pain and pain was not addressed). --8/1/18, Nurse Communication to Physician Order: Situation/Background: R5 has been having right hip pain on and off for approximately 2 weeks. No injury. Unable to schedule appointment with you for 2 weeks. Would you like her to be seen in urgent care or can you fit her in? Physician/Provider Response: MD-A indicated: Please remind staff that this should be mentioned when I round. I saw her twice during the last couple weeks and this was not mentioned. I have openings next week or she can be seen in same day care. --8/1/18, PN at 8:34 a.m. R5 continued to complain of right hip pain with no injury. Appointment scheduled for 8/3/18 with PCP. Notified daughter, she is unable to attend appointment. --8/2/18, PN at 2:40 p.m. hip pain rated 6/10, moaning. --8/3/18, PN at 10:52 p.m. leg pain rated 5/10. --8/6/18, PN at 2:34 p.m. hip pain. --8/6/18, PN at 10:52 p.m. hip and foot pain rated 7/10, restless, agitation, anxiety, screaming, grimacing, guarding or protecting body parts. Interventions included: worked with relaxation techniques, heat application given, repositioned for comfort. Pain unrelieved at 2:14 a.m. --8/7/18, PN at 7:31 a.m. hip pain, grimacing. --8/7/18, PN at 2:50 p.m. hip pain, restlessness, anxiety, withdrawal, screaming. --8/8/18, PN at 11:15 a.m. She has been having right hip pain and has been receiving PRN Tylenol for pain control. Spoke with daughter about keeping her scheduled appointment for 8/14/18 or being seen sooner. She agreed she	F 684		

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could be seen in Same Day Care on 8/10/18 and she will meet at the clinic.
--8/8/18, PN at 12:57 p.m. hip pain rated 7/10.
--8/8/18, PN at 5:55 p.m. hip pain rated 8/10.
--8/9/18, PN at 12:19 a.m. continuous hip, foot, and leg pain, limits mobility, change in mood, change in behavior, insomnia. Restlessness, anxiety, screaming and moaning. Two Tylenol given for complaint of pain in left hip and legs/feet. Resident was repositioned in bed and legs/feet were elevated due to increased edema. Music is turned on in room for distraction. Lights reduced to a minimum to promote sleep.
--8/9/18, PN at 6:57 a.m. hip pain rated 7/10.
--8/9/18, PN at 1:44 p.m. hip pain rated 6/10.
--8/10/18, PN at 7:52 a.m. hip pain rated 7/10, screaming, moaning.
--8/10/18, PN at 8:00 a.m. transported to urgent care for intermittent right hip pain at this time.

R5's Office Visit note dated 8/10/18, indicated R5 had been having problems with pain in her hip. Nobody was quite sure when it had begun. R5 complained of pain to right hip with movement but had no pain when not moved. X-rays were reviewed and R5 was noted to have osteopenia (condition in which bone mineral density is lower than normal) present and was noted to have a subcapital displaced femoral neck (extending through the junction of the head and neck of femur) fracture. The fracture margins were rounded and smoothed, suggestive that several weeks had passed since R5's fracture occurred. The physician's impression was subacute to possible chronic femoral neck fracture of right hip. The recommendation was non-surgical treatment.

R5's electronic medication administration record

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(EMAR) Monthly Report for July 2018 and August 2018, included an order for acetaminophen 325 milligram (mg) administer 2 tablets by mouth as needed (PRN) every six hours for pain. No other orders for pain medication were available until 8/10/18, when the acetaminophen order was changed to 1000 mg 3 times daily for fracture of neck of right femur and a new order for Tramadol 50 mg PRN 3 times daily for fracture of part of neck of right femur was added.

R5's medical record revealed the following trend in R5's use of PRN acetaminophen. Documentation indicated the resident did not always obtain relief from the acetaminophen.

7/1/18 to 7/15/18: 1 time
7/16/18 to 7/31/18: 13 times
8/1/18 to 8/10/18: 12 times

R5's Mood & Behavior - Incident Based report dated 7/1/18 to 8/31/18, indicated R5 exhibited such behaviors as verbal and physical aggression, yelling, insomnia, anxious complaints, repetitive verbalizations, and unpleasant mood. The report revealed the following trend in R5's behaviors:
--7/1 to 7/15: 11 instances of behaviors
--7/16 to 7/31: 11 instances of behaviors
--8/1 to 8/15: 24 instances of behaviors
--8/16 to 8/31: 9 instances of behaviors

R5's record lacked a comprehensive assessment of R5's increased pain and behaviors to triage the immediacy of need for intervention and treatment.

On 8/30/18, at 1:51 p.m. licensed practical nurse (LPN)-A stated R5 went through phases of being extremely tired, to hollering out, to periods of

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contentment. LPN-A indicated she was not aware of R5's hip fracture. LPN-A stated they had increased R5's Tylenol lately and she seemed better. LPN-A indicated R5 used to be awake at night and more restless during the day but she seemed to be better with pain. LPN-A also stated R5 was not really able to express her pain so they looked for pain indicators such as restlessness, yelling out, grimacing and not sleeping at night.

--At 1:57 p.m. nursing assistant (NA)-M stated R5 had been about the same as before before they identified her hip fracture. NA-M stated R5 seemed content and happy now. NA-M indicated she could not speak to how R5 was right before the hip fracture was identified and stated she had not noticed any major differences.

--At 2:01 p.m. NA-N and NA-L stated R5 did more hollering in the evening and sometimes in the early morning. NA-L indicated she also worked as a trained medication assistant (TMA) and stated R5 had complained of hip pain and could tell them the hip was hurting before the fracture was identified. NA-L indicated they tried non-pharmacological interventions for pain and she had been receiving Tylenol, which seemed to help. NA-L stated the hip pain had been something new R5 had not complained of before.

--At 2:06 p.m. registered nurse (RN)-A confirmed R5 had an emergency room (ER) visit on 7/17/18, for a urinary tract infection and also had been seen in urgent care for high blood pressure on that date. RN-A confirmed R5 had complained of leg pain on 7/17/18, and had first complained of right hip pain on 7/19/18. RN-A verified R5 then developed a blister on her right heel on 7/21/18,

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and had been seen by MD-A on that date. RN-A confirmed MD-A had not addressed R5's right hip pain at that time. RN-A verified MD-A had again seen R5 on 7/30/18, but had not addressed the hip pain. RN-A stated they had made an appointment for R5 to be seen on 8/3/18, however, the daughter was unable to attend and the appointment was rescheduled for 8/13/18. RN-A indicated they had been able to get an earlier appointment and R5 was seen on 8/10/18. RN-A indicated there was no documentation of an injury or accident for R5.

--at 2:51 p.m. the director of nursing (DON) clarified R5's 8/3/18, appointment had been canceled by MD-A. DON verified R5 had experienced no accidents or injuries. DON stated R5's pain had been intermittent and the only time she had expressed pain was when she had been laying in bed. DON stated they would give R5 Tylenol and get her up and she would be content. DON stated as the pain had not been consistent, she could understand why the nurses on duty had not informed MD-A of R5's pain when MD-A had been at the facility. DON indicated they had been trying to get R5 an appointment due to the change in her condition, however, verified there was no documentation of a nursing assessment of the change. DON stated they had been allowing MD-A to make the assessment as that was what MD-A preferred. DON stated they notified MD-A of the change and waited for her to make the assessment. DON verified they notified MD-A of the change on 8/1/18 and R5 was seen on 8/10/18.

On 8/31/18, at 10:28 a.m. MD-D stated she had been a little annoyed R5's right hip pain had not been brought to her attention as she had been in

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the facility to see R5 twice prior to having been notified. MD-A stated it was a strange response to defer the assessment to her and indicated she would not have expected an orthopedic assessment but an RN assessment would have been helpful. MD-A stated she would have like to have known about R5's pain sooner. MD-A stated even though it would not have necessarily have changed her care, as R5 was not a surgical candidate, pain medication may have been needed. MD-A stated the communication should have been better.

--At 11:51 a.m. RN-B stated NAs would fill out Stop and Watch forms or communicate any new concerns directly with nurses and indicated the goal was the forms ultimately went to the RN for follow up. RN-B stated if he received information about new pain he would do a head to toe assessment of the resident and then ultimately see if they needed to be seen by a physician.

--At 3:41 p.m. RN-C stated if she was notified of a change in a resident, she would assess the resident to see if further action was needed such as notify the physician or implement a nursing order. RN-C indicated most likely there should be something the nurse should be watching and let the MD know it is not clearing up and ask if there is something they would like done.

The undated Pain Management Policy directed a comprehensive pain assessment would be completed by a registered nurse on admission, with each MDS assessment thereafter, and when any new pain is identified. The policy indicated pain would be considered the 5th vital sign, checked along with the other 4 standard vital signs (temperature, pulse, respirations and blood

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F 684	Continued From page 67 pressure). The policy also indicated the physician would be notified of pain levels indicated on the pain evaluation as appropriate. The physician would also be notified when pain persisted or reoccurred despite treatment if suspected adverse consequences were noted. The Notification of Physician/Family on a Condition Change policy dated 9/2017, directed to notify the physician and resident's responsible party in the event of a status change. The policy directed the physician was to be contacted immediately for any significant change in condition as assessed by a licensed nurse.	F 684		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 688	F688: Decline in ROM:	10/17/18

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F 688	Continued From page 68 review, the facility failed to provide range of motion (ROM) restorative nursing services in order to maintain and/or prevent further decline in ROM abilities for 2 of 3 residents (R22, R5) who had not received ROM services according to individualized assessed need. R22 sustained harm due to a decline in ROM to the upper extremities. Findings include: R22's annual Minimum Data Set (MDS) dated 4/5/18 indicated diagnoses that included, but were not limited to: hemiparesis/hemiplegia, and cerebrovascular accident (stroke). The MDS indicated R22 had limitation of range of motion in the upper and lower extremity on one side, was unable to walk, and was totally dependent on one staff for all dressing and grooming activities. Review of R22's current physician orders revealed R22's restorative nursing program for range of motion had not been ordered. Review of R22's "RNA Treatment Sheet" revealed an order dated 12/4/15, which indicated R22 was to receive AROM/PROM to both upper and lower extremities one time per day. The "Special Instructions" indicated the ROM exercises to be done daily according to the restorative nursing program in the resident rehab binder. Review of R22's restorative nursing program dated 9/20/16, revealed the following instructions to be performed 3-6 times a week: -Right upper extremity active assisted range of motion (AAROM): 10 -15 repetitions of elbow flexion/extension, shoulder flexion, and shoulder abduction. Hand gripper- 20 repetitions.	F 688	R22 will be re- evaluated by an Occupational Therapist for treatment targeting level of function. An appropriate Restorative Plan will be developed when R22 is discharged in collaboration between Therapy and the Restorative Nurse. The Care Plan will be updated accordingly. R5 will be re-evaluated by an Occupational Therapist for treatment targeting level of function. An appropriate Restorative Plan will be developed when R5 is discharged in collaboration between Therapy and the Restorative Nurse. Annual training on restorative services for all staff providing restorative services was provided by the Licensed Therapist on 9/11/18 and 9/13/18. The Care Plan will be updated accordingly. The RNP books will be brought to the morning meeting weekly to ensure compliance to the residents programs. Residents who have not had their number of therapy days met will have a trained restorative aide assigned to complete the therapy timely. Restorative Nursing Program education was provided to the restorative Coordinators on 10/1/18. Random audits of the Restorative programs to ensure were being provided correctly and as ordered will be conducted by the DON/designee 2XweekX4, then weekly X4 and monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 688	Continued From page 69 -Left upper extremity passive range of motion (PROM): 10-15 repetitions of finger and thumb flexion/extension, wrist flexion/extension/pronation/supination, elbow flexion/extension, shoulder flexion/abduction and internal and external rotation. -Left lower extremity passive range of motion: hip flexion/abduction, knee flexion/extension, ankle plantar flexion/dorsiflexion and ankle inverters 2 twenty second holds. Review of the occupational therapy documentation revealed on 3/16/17, R22 had an evaluation for contracture management. The evaluation indicated R22 was unable to move the left upper extremity through full range of motion, was unable to use the left upper extremity for any functional tasks due to hypertonia and decreased ROM, had a wound and dislocated finger on the left hand due to severely decreased ROM. The decreased ROM appeared to be due to high tone in the shoulder, forearm, wrist, and hand. Occupational therapy then provided formal services to decrease R22's contracted left fingers and wrist until discharge on 5/19/17. At the time of discharge R22 was fitted with a splint device to minimize further contracture of the left hand and movement of the left fingers were achieved and measured the following. The index finger had 120 degrees of extension (60 degrees of flexion). The middle finger was able to extend to 80 degrees of flexion. The ring finger MP joint did not extend past 90 degrees of flexion. The discharge instructions included the following: Use a resting hand splint during the day and a rolled wash cloth in left hand during the night. OT recommended nursing staff check splints throughout the day and	F 688		

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routinely checks skin integrity. OT recommended the restorative nursing program be completed 7 times a week to increase/maintain ROM in left hand and left upper extremity.

R22's Care plan dated 6/12/14, did not include any interventions related to the restorative nursing program.

Nursing assistant (NA)-G provided R22's range of motion on 8/29/18, at 9:28 a.m. during which it was noted R22 received right upper extremity active assisted range of motion AAROM and was assisted with 10 repetitions (REPS) of the following: flexion and extension of the elbow, and flexion of the shoulder. NA-G did not do any shoulder abduction exercises or hand grippers as the program indicated, and did not attempt any movement of R22's right wrist or fingers. NA-G did 10 reps of PROM to the left upper extremity of the following joints: elbow flexion/extension, and shoulder extension. NA-G did not provide R22 with any wrist flexion/extension, wrist pronation/supination, finger and thumb flexion/extension on any of the digits, or shoulder flexion/abduction and internal and external rotation. PROM to the left lower extremity R22 did not receive any hip flexion, ankle dorsiflexion and ankle inverters with 2 twenty second holds. During interview with NA-G following the observation, NA-G repeatedly stated she was sorry that she did not know R22's nursing rehab program. She added that she had never been provided training on nursing rehabilitation since being hired. Although training had been scheduled in the past, the training did not occur due to a lack of staffing so when the training had been scheduled it was canceled and the person

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doing the training would be told to work on the floor rather than train NA-G on nursing rehab. NA-G stated she had repeatedly reported to the management staff that she was not comfortable providing residents nursing rehabilitation, but continued to be scheduled to provide it. NA-G stated that she had worked with R22 for the past two years and R22's hands, fingers, shoulders, and left ankle and knee were definitely tighter and harder to move.

NA-E was interviewed on 8/29/18, at 10:09 a.m. and stated she had been employed by the facility approximately 2 years, and had been assigned to provide nursing rehabilitation to the residents on 8/28/18. NA-E stated that she had never been trained by the facility how to provide nursing rehab to any of the resident's. NA-E stated she did not know how to provide R22's nursing rehab program and did not provide R22 with nursing rehab on 8/28/18, because she didn't know how to do it and she was pulled from nursing rehab to the floor at 10:00 a.m. because they were short staffed. NA-E stated it was not unusual for the nursing assistant assigned to provide the resident's with nursing rehab to be pulled to the floor so nursing rehab did not get done. NA-E stated that R22's joint movements were harder to move and moved less than when she first started.

NA-F was also interviewed on 8/29/18, at 10:09 a.m. and stated she had been employed by the facility approximately 10 months, and had been assigned to provide nursing rehabilitation to the residents but had never been trained by the facility how to provide nursing rehab to any of the resident's. NA-E stated she did not know how to provide R22's nursing rehab program.

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NA-P was observed to provide R22 with nursing rehab on 8/30/18, at 8:53 a.m. during which it was noted the following movements of R22's nursing rehab program were not completed: R upper extremity shoulder abduction not completed, left lower extremity dorsiflexion of the ankle, hip abduction, and the stretch to the hamstring, and ankle inverter stretches 2 reps with hold for 30 seconds had not been performed. NA-P stated that R22 was much more contracted now than he was a couple of years ago. NA-P was interviewed following the observation and stated she had been an employee for many years and had been trained to perform ROM exercises by a nursing assistant who is the main nursing rehab aide. NA-P stated that when a resident gets a new restorative nursing program the licensed therapy staff will train the lead nursing rehab aide to the restorative nursing program, and then then the lead nursing rehab aide will train all of the other aides. NA-P stated she had never been observed by a licensed staff while providing ROM to ensure competency.

Review of the restorative nursing treatment sheets for August 2018 revealed that R22 had not received nursing rehab daily according to the RNA Treatment Sheet dated 12/4/15, or three times a week per the directions in the Restorative Nursing Program directions dated 9/20/16, or 7 times a week according to the discharge instructions from the occupational therapy discharge summary dated 5/19/17.

In August 2018 R22 was provided the restorative nursing program 1 time in the first week from 8/1/18 - 8/5/18, twice in the second week from 8/6/28 - 8/12/18, three times in the third week

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from 8/13/18 -8/18/18, and once in the fourth week from 8/20/18 - 8/26/18.
In July 2018 R22 was provided the restorative nursing program 2 times in the first week from 7/1/18 -7/7/18, 2 times in the second week from 7/8/28 - 7/14/18, three times in the third week from 7/15/18 -7/21/18, and 5 times in the fourth week from 7/22/18 - 7/28/18.
In June 2018 R22 was provided the restorative nursing program 3-5 times a week.

R22 was observed on all days of the survey and a splint device was never observed to be used on R22.
R22's record was reviewed and there was no documentation which described when R22's splint device had been discontinued by the physician or the reasons for why the splint device had been discontinued.

Registered nurse (RN)-B was interviewed on 8/30/18, at 3:35 p.m. during which he stated that he and RN-C were in charge of the nursing rehab program. RN-C was also present during the interview and both of them confirmed that they have a nursing assistant that provided the restorative nursing program to the facility's residents and that lead nursing assistant is the person who trains the other nursing assistants how to provide the residents their restorative nursing programs. Neither RN- B or RN-C makes observations of the nursing assistants to ensure the restorative nursing programs are completed correctly and they are not aware if anyone from PT or OT makes observations of the nursing assistants either. They both confirmed they do not review the restorative nursing documentation at the end of the month to ensure the residents are receiving restorative nursing according to

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their written plans either. Additionally, they were not aware that a quarterly or annual resident screening for ROM abilities was completed either. Both RN-B and RN-C confirmed they relied on the nursing assistants who provide nursing rehab to report a decrease in ROM abilities and if or when that occurs they request an evaluation from PT or OT. They both confirmed they had not been notified R22 had any decline in ROM abilities. When asked what happened to the splint device R22 had been recommended to wear in the occupational discharge summary dated 5/19/17, neither RN-B nor RN-C could identify what happened to the splint, and did not know why R22 was not wearing the splint device, and when R22 stopped using the splint device.

The occupational therapist registered (OTR) was initially interviewed on 8/31/18, at 8:25 a.m. and stated she expected R22 to have ROM for both upper and lower extremity 7 days a week according to the OT discharge instructions dated 5/19/17. The OTR confirmed that R22's left upper extremity mainly the mp (metacarpophalangeal) joints of the left hand fingers were more contracted than at the time of discharge on 5/19/17. The OTR stated that R22 was not getting ROM enough to stop the contractures from occurring or increasing. The OTR stated that family of R22 complained the left hand splint was placed on the left hand wrong, and the OTR had also observed that the splint had been placed on wrong which made the family upset. Family decided that they did not want it used if the staff was not able to place the splint on correctly. The OTR was not sure if the risk and benefit of not using the splint device had been explained to the family.

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The OTR was again interviewed on 8/31/18, at 9:23 a.m. during which she stated she assessed R22 and was able to get R22 to have full extension of the elbow and shoulder, but not full flexion. The OTR stated that
R22's index finger had 130 degrees extension and 90 degrees flexion, the middle finger had 110 degrees extension and 70 degrees flexion, the ring finger had 80 degree's extension and 90 degrees flexion and the ring finger had 80 degrees extension, and 110 degrees of flexion. The OTR confirmed R22 was more contracted in the ring finger and little finger (pinky). The OTR had not measured the flexion and extension of the wrist elbow and shoulder for comparison.

R5's quarterly MDS dated 5/29/18, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease, muscle weakness, pain and stroke. The MDS indicated R5 required extensive assistance with activities of daily living (ADL), was non-ambulatory, and had no functional limitations in range of motion of her upper or lower extremities.

R5's ADL Nurse's Observation dated 8/21/18, indicated R5 had experienced no changes in ADL's since the last assessment. Ambulation had not occurred. R5 was chair bound with assist of two staff using Hoyer lift (mechanical lift). Balance test was not completed related to R5's right hip fracture and R5 was non-weight bearing. R5 required extensive assist of one with bathing, dressing, grooming, oral hygiene and with bed mobility. R5 was on a restorative nursing program (RNP) with goals to maintain strength and mobility for daily activities. R5 was dependent on staff for mobility due to diagnosis of stroke with hemiplegia to left upper and lower

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extremities along with new diagnosis of right hip fracture. R5 had full ROM to right upper and limited to right lower extremity due to fracture.

R5's Physicians Order Sheets dated 7/1/18 and 8/31/18, included the following orders:
--active range of motion (AROM) to bilateral upper extremities (BUE) as indicated 3-6 x/week. Reference RNP specific programs per resident in rehab binder. Start date 2/26/18
--AROM to bilateral lower extremities (BLE) as indicated 3-6 x/week Reference RNP specific programs per resident in rehab binder. Start date 2/26/18.
--ROM to BLE and right upper extremity (RUE) strength and left upper extremity (LUE) passive range of motion (PROM) all joints. Refer to RNP for program specifics. Start date 4/3/18.

R5's Care Plan reviewed 6/13/18, indicated R5 was non-ambulatory and identified a goal for R5 to maintain overall strength and ROM. The Care Plan directed staff implement interventions which included:
--AROM to BUE and BLE 3-6 x/week
The Care plan indicated R5 would refuse to work with RNP.

On 8/30/18, at 7:11 a.m. R5 was observed resting quietly in bed, positioned on her left side.
--At 7:13 a.m. NA-M entered R5's room and greeted R5. NA-M checked R5's incontinent brief, then assisted R5 to roll onto her back and NA-M lowered her pants and removed the brief. NA-M provided perineal care and provided cues and assistance for R5 to roll back again after assisting R5 to don a clean brief. RN-A entered the room with mechanical lift and RN-A and NA-M

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transferred R5 to the Geri chair with the use of the lift. NA-M wheeled R5 into the bathroom, set up and provided cues for R5 to brush her teeth, comb her hair and wash her hands. No range of motion exercises were provided.

R5's Occupational Therapy (OT) Discharge Summary dated 3/16/18, indicated R5 was discharged from OT due to reaching her PLOF (previous level of functioning). R5 was completing ADL's at her previous level. OT recommended R5 complete RNP to increase/maintain strength in UEs for functional use on ADL's. RNP put in place for 3-6 x/week.

R5's Restorative Nursing Program dated 3/29/18, indicated the type of restorative program was ROM and the goals of the program were to improve/maintain strength and mobility for daily activity 3-6 x/week. The description of the program included the following:
--lower extremity (LE) stretching
--arm bike with RUE, 5 minutes
--arm exercise RUE - 2 lb [pound], 10-15 repetitions (reps), 2 sets. Punch-outs, biceps curls, shoulder flexion, wrist pronation/supination
--PROM to left arm - 10-15 reps, 2 sets. Elbow flexion/extension, shoulder flexion, horizontal shoulder adduction, should abduction.

R5's RNA Treatment Sheets for June 2018, July 2018 and August 2018 revealed R5 received restorative nursing services as follows:
--week of 6/3: 2 times
--week of 6/24: 2 times
--week of 7/8: 2 times
--week of 8/5: 2 times
--week of 8/12: 2 times
--week of 8/19: 2 times

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F 688	Continued From page 78 --week of 8/26: 2 times On 8/31/18, at 2:56 p.m. NA-C stated NA-O was the primary restorative nursing assistant. NA-C indicated when NA-O was not there the NAs on the floor were responsible to provide restorative nursing services for their residents. --At 3:08 p.m. NA-C stated the NA's who worked the floor did not have time to provide the restorative nursing services so residents often did not receive the services if NA-O was not there. --At 5:14 p.m. RN-A verified the RNA Treatment Sheets for R5 indicated she had not received services 3-6 x/week as directed on the weeks identified above. RN-A stated when NA-O was gone the services should have been provided by the NA's working the floor. RN-A confirmed R5 was not provided the services as directed. Review of the facility policy Restorative Nursing Program Policy (Undated) revealed the following: "It is the policy of (facility name) to provide a Restorative Nursing Program which focuses on achieving and/or maintaining optimal function in accordance with the comprehensive assessment and plan of care."	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		10/17/18

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F 690	Continued From page 79 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medical justification for the ongoing use of an indwelling urinary catheter was identified for 1 of 2 residents (R59) reviewed for urinary catheter use. Findings include: R59's quarterly Minimum Data Set (MDS) dated 5/22/18, indicated R59 had moderate cognitive	F 690	F690: TRCC□s goal is to ensure a resident is not catheterized unless the resident□s clinical condition demonstrates that catheterization was necessary. R59□s catheter was reassessed by the RN Nurse Manager and it is determined that there continues to be an adequate justification for the use of the catheter. The physician reassessed the resident and determined the resident does have	

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F 690	Continued From page 80 impairment and diagnoses which included cerebral aneurysm, seizure disorder and depression. The MDS indicated R59 required extensive assistance of two persons for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS also indicated R59 was always incontinent of urine and bowel and a current toileting program or trial was not being used to manage R59's urinary continence. R59's Physician Order Sheet dated 8/31/18, included the following orders: --Tube Feeding enteral tube every 8 hours at 2:00 a.m. 10:00 a.m. and 6:00 p.m. for dysphagia. Isosource HN (Food Supplement, Lactose-Reduced) 0.05 gram - 1.2 kcal [kilocalories]/milliliter (ml) liquid. Administer 500 mls over three hours or 166 ml/hour --Metamucil powder 3.4 grams/5.4 gram: Administer 1 tablespoon via enteral tube two times per day for loose stools. Mix with 240 ml of water. --Change Foley catheter on the 1st of the month: 16 French, 10 ml balloon R59's General Nurses' Observation for Skin dated 8/16/18, indicated R59 was at low risk for skin breakdown. She was on a turning and reposition program scheduled every two hours with assist of 1-2 staff. R59 would not stay positioned on her right or left side but would return to lying on her back. R59 was a risk for friction/shearing due to having the head of bed elevated 45 degrees or more during tube feeding and R59 tended to slide down in bed. R59 had a PEG [percutaneous endoscopic gastrostomy] tube (tube passed into the stomach through the abdominal wall) placed on 10/18/17, due to silent aspiration. R59 was always incontinent of bowel	F 690	justification for the catheter use. The resident who is incontinent of urine and bowel indicates she does not want the catheter removed due to her history of serious breakdown on her bottom without it. Audits of all residents with a catheter will be conducted to ensure there is an adequate justification for catheter use was completed by 10/17/18 Audit results were brought to the QAPI Committee for review and further recommendation,	

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and had a Foley catheter in place. R59 had redness to her rectal area due to frequent loose bowel movements. Tena cream (protective cream) was applied to redness with incontinent episodes. She had scheduled Metamucil twice daily to help with loose bowel movements. Skin was inspected weekly by licensed staff.

R59's General Nurse's Observation for Bladder dated 8/16/18, indicated R59 had a Foley catheter placed in June 2018, due to diarrhea and urine incontinence affecting skin integrity. The observation indicated R59 required extensive assitance of 1-2 staff to check and change incontinent product every three hours and R59 did not have a diagnosis of urinary tract infection.

R59's General Nurse's Observation for Bowel dated 8/16/18, indicated R59 was always incontinent of bowel, wore a brief and was assist of 1-2 staff for incontinence cares. R59 was encouraged to use the toilet, but she refused. R59 was taking scheduled Metamucil (fiber supplement) twice daily which had helped with diarrhea. Bowel movements were monitored daily by nursing staff.

R59's care plan reviewed 6/5/18, indicated R59 had an indwelling catheter, a PEG tube and was at risk for altered skin integrity related to impaired mobility. The Urinary Incontinence/Indwelling Catheter care plan goal indicated catheter would be discontinued following perineal wound healing of at least four weeks. The plan directed staff to implement interventions which included:

--assess the catheter drainage system, assist R59 with good personal hygiene, change catheter system monthly, observe for signs and symptoms

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of infection and report changes, record intake and output and use flat pads to maintain skin integrity.
--observe for diarrhea.
--turn and reposition eery two hours to help prevent skin break down
--report any skin condition to the nurse

On 8/31/18, at 9:51 a.m. nursing assistant (NA)-B and NA-J were observed providing R59 morning cares. NA-B and NA-J assisted R59 to wash face, armpits and under breasts and then donn a shirt. NA-B uncovered R59's lower body, washed her groin and cleaned her catheter tubing. Skin to the groin area was intact without redness. NA-B and NA-J assisted R50 to turn onto her right side. R59 had been incontinent of stool. NA-B stated as far as she knew, R59 had not had problems with the integrity of the skin in her groin area however, R59's bottom got sore. R59's buttocks was noted to have intermittent coatings of a white occlusive-type cream with areas of skin exposed along the gluteal crease and both buttocks were dark, beefy red, and inflamed. NA-J stated R59 had constant stooling and her skin problems on her buttocks began when the tube feeding was started. The skin was not open or bleeding. NA-B stated they had tried different incontinent products, had changed from a full style brief to a flat pad, and tried different types of creams and sprays on her skin to try and help the soreness. As NA-J cleansed R59's bottom, liquid stool was oozing from the rectum. R59 stated her bottom was painful.

Review of R59's medical record revealed the following:

-Physician Progress Note dated 5/14/18, indicated R59's rash in the groin and abdomen

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had cleared.
-Nurse Communication to Physician Order dated 6/1/18, section entitled "Situation/Background" indicated R59 had moisture associated skin damage to perineal [sic] due to always incontinent of bladder and bowel. Has progressively got [sic] worse. Interventions used include Tena protective cream, miconazole nitrate (antifungal), toileting schedule of every 2 hours, turning and repositioning - have not been successful in helping heal. Section entitled "Request" indicated Interventions - have catheter (Foley) placed to help heal skin. Physician/Provider Response indicated place Foley indefinitely.
-Untitled form dated 6/1/18 identified: type of catheter: indwelling, size 16 French balloon 10 mls. Frequency of change: monthly. Medical necessity/reason for use/duration of use: A handwritten asterisk was placed next to the statement "Open sacral or perineal wounds affected by incontinence that prevents ulcer healing (catheter will be discontinued following wound healing of at leave 4 weeks based on individual assessment." Next to Resident's choice (documented risk/benefit on chart) was handwritten "she has agreed has helped in the past."
R59's record lacked indication of open areas and an appropriate justification for the use as well as a plan for the removal of the catheter.

On 8/31/18, at 10:08 a.m. registered nurse (RN)-A verified R59 had not had a pressure ulcer to her bottom and confirmed R59 had extremely loose bowel movements (BM). RN-A verified the stooling increased or started when R59's tube feeding was initiated. RN-A indicated R59 had been changed from a bolus tube feeding to feedings every eight hours and had been started

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on Metamucil for her watery diarrhea. RN-A indicated the catheter was requested to see if it would help improve R59's skin maceration. RN-A stated R59 was not compliant with her turning and repositioning program and would go right back onto her back after repositioned on her side therefore not allowing pressure relief to her bottom. RN-A indicated they had tried changing from briefs to flat pad for more air circulation and had changed the type of wipes used for R59 in an attempt to improve her skin maceration. RN-A verified the catheter was approved on 6/1/18, and confirmed there had been an improvement to the skin with the use of the catheter and Metamucil. RN-A verified R59's catheter order was for an indefinite time period with no plan to discontinue at this time. RN-A stated she did not believe the staff had tried a more frequent check and change program for R59's incontinence nor had they tried a different type of tube feeding formula in an attempt to address R59's diarrhea prior to inserting the catheter. RN-A stated they had used a catheter before when R59 had experienced issues with macerated skin and at that time, it had taken some time for R59's bladder function to return after the catheter was discontinued.

--At 2:16 p.m. the director of nursing (DON) stated R59 had always had "bad skin," "bad stool," and had very frequent soft stools. The DON verified the tube feedings had exacerbated the stool incontinence however, stated it had always been an issue. The DON confirmed R59 did not have a neurogenic bladder and had not been seen by urology. The DON indicated R59's skin issues had been ongoing for the last 3-4 years and stated it had been a "vicious cycle" with her skin integrity and felt both the urine and stool incontinence contributed to the problem. The

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F 690	Continued From page 85 DON verified the physician had seen R59 for a groin rash in May 2018, but had not assessed R59's skin since that time. A policy related to catheter use was requested but not received.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive nutritional assessment for 1 of 1 resident (R51) reviewed with significant weight loss	F 692	F692: TRCC ensures each resident with a weight loss has had a comprehensive nutritional assessment. R51 had a comprehensive Nutritional Assessment completed by the facility□s dietician on 9/4/18 with revision made to	10/17/18

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F 692	Continued From page 86 Findings include: R51's quarterly Minimum Data Set (MDS) dated 7/31/18, indicated R51 had severe cognitive impairment and diagnoses which included dementia, heart failure, epigastric pain, edema, gastroesophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of your esophagus), and diverticulosis (pockets which form in the walls of your digestive tract). The MDS indicated R51 required extensive assistance of one person with all activities of daily living (ADL) including eating. The MDS also indicated R51 had complaints of difficulty or pain with swallowing. The MDS further indicated R51's height was 64 inches and weight was 103 pounds (lbs) and indicated this represented no or unknown weight loss of 5% or more in the previous month or 10% or more in the previous 6 months. R51's current care plan reviewed 5/18/18, indicated R51 was at risk for shortness of breath, edema or chest pain related to congestive heart failure and directed staff to implement interventions which included: assess R5 for understanding and compliance with plan of care such as medication, diet and activity level, provide diet per physician (MD) order, and monitor weights weekly. However, the care plan did not address R51's nutritional risk, nutritional interventions, or assistance requirements with eating. R51's Physicians Order Sheet dated, 7/1/18, included a dietary order for mechanical soft, honey thickened liquids.	F 692	the plan of care. An audit of all residents with weight loss was completed on 9/3/18 to ensure comprehensive Nutritional Assessments had been done, with any current assessments completed by 10/17/18. The Registered Dietician and Assistant Dietary Manager were educated on the completion of comprehensive Nutritional Assessments on residents on 9/3/18. The DON/designee will audit weight loss reports on a weekly basis to ensure any resident with a weight loss has a comprehensive Nutritional Assessment to identify the cause. Audit results will be brought to the QAPI Committee quarterly for review and further recommendations where necessary.	

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R51's Physicians Transcribed Order dated 7/31/18, included an order for Nutritional Drink: administer 237 milliliters (ml) three times per day, document supplements document CC's [ml] consumed. The order start date was 7/31/18.

On 8/29/18, at 8:33 a.m. R51 was observed in the dining room, seated in a wheelchair. R51's breakfast meal was on the table in front of her, however, R51 was not eating. R51's meal consisted of cheese omelet, toast, juice, water, coffee, and mini donuts. R51 had eaten 1/2 piece of toast.
--At 8:37 a.m. nursing assistant (NA)-C was feeding R51's tablemate. No cues were provided to R51 to eat.
--At 8:38 a.m. R51 looked around the room but made no attempt to eat. NA-C asked R51 how her breakfast was and R51 responded "Good."
--At 8:41 a.m. registered nurse (RN)-A asked if R51 was hungry and asked R51 if she would like another piece of toast. R51 refused.
--At 8:43 a.m. RN-A again approached R51 and asked if she was ok and wanted any more breakfast. RN-A sat next to R51 and fed her a bite of the omelet.
--At 8:46 a.m. RN-A wheeled R51 from the dining room. R51 had consumed 1/2 a piece of toast, approximately 1/2 a cup of coffee, and a bite of the omelet.

On 8/30/18, at 8:27 a.m. R51 was wheeled into the dining room and positioned at a table. R51 was greeted by ward clerk (WC)-A who took R51's breakfast order of cream of wheat, waffles, toast, oranges, milk and coffee.
--At 8:31 a.m. WC-A delivered R51's breakfast, set up the meal and left. R51 started to eat the

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waffle independently. No staff observed at the table to assist.
--At 8:35 a.m. R51 was noted to be salting her cereal and then added more sugar.
--At 8:38 a.m. NA-L sat at the table to assist R51's tablemate. R51 continued to eat the cream of wheat independently.
--At 8:39 a.m. NA-L assisted R51 move the bowl of cereal closer to her.
--At 8:44 a.m. R51 continued to feed herself and drank the coffee independently.
--At 8:47 a.m. R51 sat with her hands in her lap. R51 picked up piece of toast and took a bite
--At 8:55 a.m. R51 sat with hands in lap. NA-L prompted R51 to eat more of her breakfast.
--At 9:04 a.m. R51 stated she was done eating and she was not very hungry. NA-L wheeled R51 from the table. R51 had consumed approximately 25% of the cereal, bites of the waffle, 1/2 a piece toast, 100% of the oranges and drank approximately 75% of the coffee.
NA-L stated sometimes R51 ate and sometimes she did not. NA-L indicated the staff encouraged R51 as much as possible but stated R51 would become angry if they pushed her too much.

R51's medical record revealed the following:

2/4/18: 128.4 lbs.
2/7/18: Dietary Note completed by the dietary manager (DM): Dietary Preference - regular diet, Weight Gain/Loss - none, Special Dietary Programs - none, Skin Condition Comments - none General Dietary Comments: Resident is 64 inches tall, 128.4 lbs, 22 BMI [body mass index]. Resident is able to make her own choices at meal times and feed herself after setup from nursing. Resident stated she does not like tossed salads. Resident does like pancakes, French toast,

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bacon, meat and potatoes. She likes the food here and does not have any food allergies at this time.
2/8/18: 129 lbs
2/18/18: 133.2 lbs
2/19/18 to 2/22/18 Hospital admission for CHF [congestive heart failure] exacerbation, pneumonia
2/24/18: 123.4 lbs
2/25/18: 118.4 lbs
2/27/18 to 3/8/18: Hospital admission for cardiac issues and CHF exacerbation
MD progress Note: 4/14/18: admitted to hospital for acute on chronic right heart failure. Patient was diuresed with furosemide and treated with metoprolol, Diltiazem and eventually digoxin [cardiac medications].
3/10/18: 110.6 lbs
3/12/18: 105 lbs
3/28/18: Nutrition Note: continues to have poor appetite current weight is 102.6. Nutritional supplements implemented bid [twice daily].
4/1/18: 104 lbs
4/13/18: registered dietitian (RD) Progress Note: RD reviewed chart. R51 has had a 16.82% weight loss in 180 days, was started on a nutritional supplement on 3/28, 237 ml bid to help with weight loss. Since this time R51 had gained about 4 lbs. R51 is on a mechanical soft honey thickened liquids. Her likes and dislikes have been communicated to the dietary staff. R51 needs encouragement with meals and snacks, continue providing encouragement, most recent weight was 106.8 from 4/12/18. Continue with current nutrition plan of care and with supplement bid. If weight doesn't continue to increase and she is accepting the supplements, increase to TID [three times daily]. If further nutritional questions or concerns, contact RD.

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4/24/18: RD Progress Note indicated the RD had a conversation with the DM about R51's nutritional status and increasing her supplements to TID. R51's most recent weight is 104 and her eating changes each day pending on her mental status that day. Contact the RD with any nutritional questions or concerns.
5/3/18: 106.2 lbs
6/3/18: 104.4 lbs
7/1/18: 104.2 lbs
7/29/18: 102.8 lbs
8/12/18: 101.6 lbs
8/15/18: 100.9 lbs
8/19/18: 102.8 lbs - a 22.8% weight loss in 6 months
8/29/18: 100.9 lbs - a 14.7% weight loss in 6 months.

Review of R51's hospital records from the 2/27/18 to 3/8/18 hospitalization revealed a Dietitian Follow Up dated 3/6/18, which identified R51's intake had been poor and recommended nectar thick liquids and NDD3 foods [National Dysphagia Diet level 3 - includes moist foods in bite-size pieces] and frequent offerings of foods/liquids as diet order allowed was also recommended. However, R51's medical record lacked follow through of the hospital dietitian's assessment recommendations and also lacked a comprehensive nutritional assessment by the facility dietitian to identify R51's nutritional needs and goals.

On 8/30/18, at 11:42 a.m. the director of nursing (DON) and the facility nursing consultant (NC) indicated newly admitted residents had a nutritional assessment completed within 14 days of admission in order to complete the MDS. The NC stated the DM usually completed MDS

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F 692	Continued From page 91 nutritional assessment and the RD saw the residents monthly. On 08/30/18, at 3:11 p.m. the DON stated R51's dietary risk score upon admission was 1 (low or no risk) and her nutrition/weight loss risk score was 4 (normal). Review of R51's nutritional supplement intake for the previous 30 days revealed intake ranged from 50-100% with occasional refusal of the supplements. The DON verified no comprehensive nutritional assessment had been completed for R51. In addition, the DON stated the facility was in the process of evaluating the facility's provision of nutritional services.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen tubing was changed according to facility policy for 1 of 2 residents (R51) reviewed for respiratory care. Findings include: R51's Face Sheet dated 8/30/18, indicated R51 had diagnoses which included panlobular	F 695	F695: TRCC ensures appropriate respiratory care is provided, including labeling and dating when the oxygen tubing is changed. R51□s O2 tubing was labeled and dated when changed on 9/7/18. Nursing staff were re-educated on the facility□s Oxygen policy regarding labeling and dating of O2 tubing in order to show	10/17/18

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F 695	Continued From page 92 emphysema (a type of chronic obstructive pulmonary disease), pneumonia and heart failure. R51's quarterly Minimum Data Set (MDS) dated 7/31/18, indicated R51 had severe cognitive impairment and required extensive assistance of one person with all activities of daily living (ADL). The MDS also indicated R51 received oxygen therapy. R51's Physician Order Sheet dated 7/1/18, included a treatment order for oxygen at 2 liters (L) via nasal cannula continuous for panlobular emphysema. Document oxygen saturation in vitals. The order start date was 3/8/18. R51's care plan reviewed 5/18/18, indicated R51 had a potential for alteration in respiratory status related to CHF [congestive heart failure] and panlobular emphysema. The plan directed staff to administer inhalers, nebulizers, medications and oxygen as ordered and to monitor oxygen saturation. R51 could leave the oxygen off if no change in respiratory status and oxygen saturation was 90% or greater and also indicated R51 often removed the oxygen independently without a change in respiratory status. On 8/27/18, at 4:41 p.m. R51 was observed seated in a wheelchair in the common area. A portable oxygen concentrator was attached to the back of R51's wheelchair and R51 wore a nasal cannula. The oxygen tubing was not labeled or dated. --At 4:55 p.m. an oxygen concentrator was observed in R51's room. The oxygen humidifier bubbler bottle and tubing attached to the concentrator were not labeled or dated.	F 695	proof when it was changed on 10/1/18. Random audits of O2 tubing will be conducted weekly X 8 and monthly thereafter to ensure tubing is being labeled and dated when changed. Audit results will be brought to the QAPI Committee for further review and recommendations.	

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On 8/29/18, at 7:26 a.m. nursing assistant (NA)-A assisted R51 with morning cares and upon completion, wheeled R51 to the hall beside the nurses station. NA-A retrieved a new portable oxygen concentrator and swapped the one attached to R51's wheelchair with the new one. NA-A moved the nasal cannula oxygen tubing to the new portable oxygen concentrator.

On 8/30/18, at 11:23 a.m. R51 was observed seated in a wheelchair, in her room. The oxygen tubing remained unlabeled and undated on both the portable and large concentrators in R51's room.

--at 11:24 a.m. licensed practical nurse (LPN)-B stated the residents' oxygen tubing was changed weekly, usually by the night shift and was documented on the ETAR [electronic treatment administration record], however, verified the staff did not mark the tubing to identify the date changed.

On 8/31/18, at 2:52 p.m. LPN-C confirmed oxygen tubing was changed weekly on Mondays, usually by the night shift. LPN-D looked up R51's ETAR on the computer system and indicated there was no documentation to indicate the tubing had been changed the previous Monday.

R51's ETAR Monthly Report for August 2018, included an order to "change oxygen and neb [nebulizer] tubing every Monday during night." NR [not recorded] was documented under the Monday entry dates of 8/13/18, and 8/27/18.

On 8/31/18, at 2:54 p.m. the director of nursing verified the ETAR lacked documentation R51's oxygen tubing had been changed 8/13/18, or

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F 695	Continued From page 94 8/27/18, as ordered. The Oxygen policy dated 5/14/18, indicated oxygen would only be provided to residents as directed by a proper physician order, including standing orders. The policy did not address the changing of oxygen tubing.	F 695		
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. §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'	F 726		10/17/18

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	245252	A. BUILDING _____ B. WING _____	08/31/2018

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(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 726	Continued From page 95 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all nursing assistants who provided nursing rehabilitation services were trained and competent. This had the potential to affect all 51 who received nursing rehabilitation services. Findings include: R22's annual Minimum Data Set (MDS) dated 4/5/18, indicated R22's diagnoses included hemiparesis/hemiplegia (one sided weakness/paralysis), and cerebrovascular accident (stroke). The MDS also indicated R22 had limitation of range of motion in the upper and lower extremities on one side, was unable to walk, and was totally dependent on one staff for all dressing and grooming activities. Review of R22's restorative nursing program dated 9/20/16, revealed the following instructions to be performed 3-6 times a week: -Right upper extremity active assisted range of motion (AAROM): 10 -15 repetitions of elbow flexion/extension, shoulder flexion, and shoulder abduction. Hand gripper- 20 repetitions. -Left upper extremity passive range of motion (PROM): 10-15 repetitions of finger and thumb flexion/extension, wrist flexion/extension/pronation/supination, elbow flexion/extension, shoulder flexion/abduction and internal and external rotation. -Left lower extremity passive range of motion: hip	F 726	F726: TRCC goal is to ensure staff providing restorative nursing programs are trained and competent. NA-G, NA-E, NA-F and NA-P (all staff providing restorative services) were re-educated on all restorative nursing programs by the Licensed Therapist or an RN on 10/11/18 and 10/13/18. Annual training for all Nursing staff on restorative services was done by the Licensed Therapist On 10/17/18. Restorative Nursing Program education was provided to the Restorative Coordinators on 10/1/18. Random audits of the Restorative programs being provided correctly and as ordered will be conducted by the DON/designee 2 x week X 4, then weekly x 4 and monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 726	Continued From page 96	F 726		

flexion/abduction, knee flexion/extension, ankle plantar flexion/dorsiflexion and ankle inverters 2 twenty second holds.

On 8/29/18, at 9:28 a.m. nursing assistant (NA)-G was observed to provide R22 range of motion exercises. NA-G performed right upper extremity range of motion (ROM) and assisted R22 with 10 repetitions (REPS) of the following: flexion and extension of the elbow, and flexion of the shoulder. NA-G did not do any shoulder abduction exercises or hand grippers as the program indicated, and did not attempt any movement of R22's right wrist or fingers. NA-G proceeded to perform 10 reps of PROM to the following joints: wrist flexion/extension, elbow flexion/extension. NA-G did not provide R22 with any wrist pronation/supination, finger and thumb flexion/extension on any of the digits, or shoulder flexion/abduction and internal and external rotation. During PROM to the left lower extremity R22 did not receive any hip flexion, ankle dorsiflexion and ankle inverters with 2 twenty second holds. Following the observation, NA-G repeatedly stated she was sorry that she did not know R22's nursing rehab program, and she had never received training on nursing rehabilitation services since being hired. NA-G stated although, nursing rehab training had been scheduled in the past, the training had not occurred due to a lack of staffing. NA-G stated she had repeatedly reported to the management staff that she was not comfortable providing the residents nursing rehabilitation services, but continued to be scheduled to provide it. NA-G also stated she had never been observed by a licensed staff member while providing ROM to ensure competency.

On 8/29/18, at 10:09 a.m. NA-E and NA-F were

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interviewed. NA-E stated she had been employed by the facility for approximately two years, and had been assigned to provide nursing rehabilitation to the residents on 8/28/18. NA-E stated she had never been trained by the facility on how to provide nursing rehab to any of the resident's. NA-E stated she did not know how to provide R22's nursing rehab program, and had not provided R22 with nursing rehab on 8/28/18, because she didn't know how to do it. NA-F stated she had been employed by the facility for approximately 10 months, and in the past had been assigned to provide nursing rehabilitation to the residents but had never been trained by the facility on how to provide nursing rehab. Both NA-E and NA-F stated they had never been observed by a licensed staff member while providing ROM to ensure competency.

On 8/30/18, at 8:53 a.m. NA-P was observed to provide R22 with nursing rehab and the following range of motion movements directed by R22's nursing rehab program were not completed: R (right) upper extremity shoulder abduction, left lower extremity dorsiflexion of the ankle, hip abduction, and the stretch to the hamstring, and ankle inverter stretches 2 reps held for 30 seconds had not been performed. NA-P was interviewed following the observation and stated she had been an employee for many years and had been trained on how to perform ROM exercises by a nursing assistant who was the main nursing rehab aide. NA-P stated when a resident gets a new restorative nursing program, the licensed therapy staff would train the lead nursing rehab aide to the new program, and then the lead nursing rehab aide would train all of the other aides who provided rehab services. NA-P stated she had never been observed by a

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licensed staff member while providing ROM to ensure competency.

On 8/30/18, at 3:35 p.m. registered nurse (RN)-B and RN-C were interviewed. RN-B stated he and RN-C were in charge of the nursing rehab program. Both RN-B and RN-C confirmed they had a lead restorative nursing assistant who provided the restorative nursing program to the residents, and that lead restorative nursing assistant was the person who trained the other nursing assistants on how to provide the residents their restorative nursing programs. Both RN-B or RN-C confirmed they had not observed the nursing assistants providing restorative services to ensure the restorative nursing programs are completed correctly and they were not aware if anyone from physical or occupational therapy had observed the nursing assistants to ensure competency.

On 8/31/18, at 10:30 a.m. the director of nursing (DON) stated all the nursing assistants who provide restorative services should have been trained by the facility's therapy department and their competency evaluation was to be documented their personal records.

On 8/31/18, at 10:53 a.m. the facility nursing consultant stated all of the nursing assistants had been trained and observed for competency by the facility's licensed physical and occupational therapists and evidence of the competency would be documented in each nursing assistants personnel record.

Review of the Thief River Care Center Facility Assessment dated 9/29/17, revealed Staff Competencies would be provided to the nursing

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F 726	Continued From page 99 assistants for Restorative Programs. Documentation of competency for restorative nursing for NA-G, NA-E, NA-F, and NA-P was requested, however, the facility had not provided any evidence they were trained and deemed competent.	F 726		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (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 maintain clean and sanitary equipment and environment in the kitchen in order to prevent the spread of food borne illness. This deficient practice had the potential to affect 68 of 68 residents residing at the facility and were served food from the kitchen.	F 812	F812: Food Procurement, Store/Prepare Serve-Sanitary The main kitchen has been deep cleaned. Scoops were removed from the flour and oatmeal, with a holder in place for a scoop. The ice machine was cleaned and put on	10/17/18

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F 812	Continued From page 100 Findings include: On 8/29/18, at 11:45 p.m. during a tour of the kitchen the following sanitation problems were observed: -Scoops found in large 20 gallon containers of flour and oat meal. -Dirt, lime scale, and food debris noted on the outside of the large ice machine. Lime scale and food debris was noted on the inside lip of the top lid of the ice machine. The dietary manager (DM) stated there was no routine cleaning schedule for the ice machine except when the maintenance department provided preventative maintenance to the machine approximately every three months. A copy of the manufacturer's instructions for routine maintenance was requested but not provided. -The inside of the convection oven was covered in grease splatters and food debris was noted at the bottom of the oven. -The outside of the reach in refrigerator's (2) were dirty with food debris spills and oil spots from hand prints. The dietary manager confirmed the outsides of the refrigerators had not been cleaned in at least a two weeks because they were short of staff when they were scheduled for cleaning which was on Wednesdays. -The outside of the reach in freezer (1) was dirty with food debris spills and oil spots from hand prints. -The large steamer had food debris and grease spills down it sides.	F 812	the cleaning schedule. The convection oven is on the cleaning schedule. The outside of the reach in fridge and reach in freezer were cleaned and on the cleaning schedule. The large steamer was cleaned and is on the cleaning schedule. The southbend flattop sides were cleaned and on the cleaning schedule. The microwave was cleaned and on the cleaning schedule. Dietary staff have been re-educated on wearing a hairnet on beards. The ADM/designee will audit the cleaning schedule for completion 3X week X 4 weeks then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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-The southbend flat top was laden with grease and built up food debris on the sides.

-The belly of the industrial stand mixer had food debris caked on it, and the dietary manager indicated the mixer was not in use and was stored clean.

-The microwave had multiple areas of caked on food debris.

-1 of 1 male staff member had a beard and was preparing food without beard net/cover. During interview with the employee he stated that he was not aware he was supposed to wear a beard covering because when he first started working in the kitchen, he was clean shaven. During interview with the DM, she stated she was unsure if there was a policy which addressed the use a beard cover.

-The Baking pans were stored in the main kitchen without being covered.

-The six burner gas stove top had many areas of caked on food debris.

During the tour, the DM stated she had just been appointed as the DM and did not have any management experience with nursing home food service.

A copy of the cleaning schedule was provided which indicated the following cleaning schedule:

-Monday: the stove top burners and flat top grill inside and outside were to be scrubbed clean.
-Tuesday: the ovens and oven racks and

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F 812	Continued From page 102 steamers (inside only) were to be cleaned. -Wednesday: the refrigerators were to be cleaned inside and outside. -Thursday: the walk in refrigerator and freezer were to be cleaned. -Friday: the pots and pans are organized and the bread proofer is cleaned. -Saturday: the utensil drawers are to be organized and the walk in freezer to be cleaned. -Sunday: the cupboards are to be wiped down and organized. The facility's policies and procedures for kitchen sanitation and cleanliness was requested but none provided.	F 812		
F 880 SS=D	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 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	F 880		10/17/18

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F 880	Continued From page 103	F 880		

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 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

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F 880	Continued From page 104 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 appropriate hand hygiene was provided and contamination precautions were implemented following perineal care for bowel incontinence for 1 of 1 resident (R22) observed during the provision of personal cares. Findings include: R22's annual Minimum Data Set (MDS) dated 4/5/18, indicated R22's diagnoses included hemiparesis/hemiplegia (one sided weakness/paralysis), and cerebrovascular accident (stroke). The MDS indicated R22 was totally incontinent of bowel and was dependent upon one staff member for personal hygiene and toilet use (cleansing self after elimination, changing pad, and adjusting clothing). Review of R22's care plan dated 6/12/14, indicated R22 required total staff assistance to provide pericare following bowel incontinence and changing incontinent pad. On 8/27/18, at 6:27 p.m. R22 was observed during the provision of incontinence care. Nursing assistant (NA)-I and NA-H assisted R22 to bed using a mechanical lift. NA-I donned gloves, lowered R22's sweat pants, and opened the incontinent product which was noted to have a	F 880	F880 TRCC has an infection prevention and control program designed to ensure appropriate hand hygiene and proper handling of soiled linen when providing perineal care. All NARs were re-educated on the facility□s policies regarding proper hand hygiene and linen handling when providing perineal cares for our residents by 10/17. Random audits of perineal care provided to residents will be conducted 3 X week x 4, then 2X week X 4 and monthly thereafter. Audits will be brought to the QAPI Committee for review and further recommendations.	

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large amount of incontinent bowel. NA-I proceeded to cleanse R22's perineum with pre-moistened wipes and removed the soiled incontinent pad. With the same gloved hands, NA-I placed a clean incontinent pad on R22 and with NA-H's assistance, rolled R22 from side to side while pulling up and repositioning R22's sweat pants and proceeded to attach the mechanical lift and transfer R22 back into the recliner. NA-I was observed to touch the mechanical lift transfer sling, R22's recliner, the handles of the mechanical lift, the controller of the mechanical lift used to elevate and lower the lift, and R22's television remote control with the same gloved hands.

On 8/27/18, at 6:27 p.m. NA-I stated following incontinent cares, the gloves should have been removed, hands should have been washed and a clean pair of gloves should have been applied immediately following cleansing R22's perineum and the removal of the soiled incontinent pad.

On 8/29/18, at 10:00 a.m. NA-E was observed to provide R22 morning cares. A basin of clean water was placed on R22's bedside stand. During perineal cares, R22 was noted to have been incontinent of bowel. NA-E cleansed R22 with a wash cloth and when finished, laid the soiled cloth directly on the bedside stand, next to the basin of water. When finished with the R22's morning cares and prior to leaving R22's room, NA-E removed the soiled wash cloth from R22's bedside stand, placed it in a plastic bag and removed it from R22's room along with R22's other soiled clothing. Following this observation, NA-E was interviewed and confirmed she should not have laid the feces soiled wash cloth on top of R22's bedside stand.

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F 880	Continued From page 106 On 8/31/18, at 10:00 a.m. the infection preventionist stated she expected that glove removal and hand hygiene be performed immediately following peri-care, and verified a soiled wash cloth should have never been set on a resident's bedside stand without first being placed in a basin or having some sort of barrier between the wash cloth and the bedside stand. The infection preventionist stated the nursing assistants had been educated on infection control procedures during morning care and peri-care during the last nursing assistant meeting which was held within the last month. On 8/31/18, at 10:30 a.m. the director of nursing (DON) stated she expected glove removal and hand hygiene be performed immediately following peri-care and before touching any other items, as directed by facility policy. Additionally, the DON stated a soiled wash cloth should have never been set on a resident's bedside stand without first being placed in a basin or having some sort of barrier between the wash cloth and the bedside stand. The facility's Hand Hygiene/Handwashing policy and procedure revised 5/8/17, directed all employees to practice proper hand hygiene to prevent the spread of infection before and after direct patient contact, if moving from a contaminated body site to a clean body site during resident care, and after removing gloves.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	**2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701**

(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 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 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 Thief River Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/26/2018

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
	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**08/28/2018**

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K 000	Continued From page 1	K 000		

STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@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

Thief River Care Center building was constructed in 2011 is 1-story, without a basement and was determined to be of a Type II (000) construction. The building is divided into three smoke zones by two smoke barriers and two 2 hour fire barriers

The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems. The facility has a fire alarm system with automatic smoke detection in the all corridors and in all common use spaces in accordance with NFPA 72 "The National Fire Alarm Code" . All sleeping rooms have smoke detection with other hazardous areas have automatic fire detectors,

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K 000	Continued From page 2 that are on the fire alarm system. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain egress in accordance with NFPA 101 (12) Life Safety Code section 7.1.10.1, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect all of the 70 residents. FINDINGS INCLUDE: On the facility tour between 7:30 am to 11:00 pm on 08/28/2018 Observations revealed: 1. The sidewalk at the Evergreen wing exit near resident room 111 was heaved over 1/2 inch in	K 211	K-0211 TRCC strives to ensure the means of egress is continuously maintained and free of all obstructions to full use in case of emergency. The sidewalk at the Evergreen wing exit near resident room 111 has been beveled. The exit door in the Blueberry wing near resident room 168 has been reconstructed per NFPA 101 Means of Egress. A full scale plan to replace and/or repair further means of egress will be devised by	10/17/18

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K 211	Continued From page 3 height without the proper beveling 2. The exit door in the Blueberry wing near resident room 168 could not open to 90 degrees due to the sidewalk was heaved. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 211	TRCC/Designee. The Environmental Services Director/Designee will monitor the stoops monthly for any egress obstructions and repairs made as necessary. A report will be submitted to the Quarterly QAPI Meeting for review and further revisions made where necessary.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1.	K 341	K-0341 TRCC strives to ensure fire alarm systems meet NFPA 101 Fire Alarm Systems code.	10/17/18

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K 341	Continued From page 4 This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of residents staff and visitors. Findings include: On the facility tour between 7:30 am to 11:00 pm on 08/28/2018 observations revealed a smoke detector within 36 inches of an HVAC diffuser at the nurses station in the Evergreen wing. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 341	The smoke detector at the nurses station in the Evergreen wing has been moved to meet NFPA 101 Fire Alarm Systems code involving smoke detector distance from an HVAC Diffuser. There are no other smoke detectors noted to be out of compliance at this time. The ESD/Designee will monitor any new construction involving HVAC diffusers and smoke detectors for compliance. The ESD/Designee will monitor for compliance of smoke detectors during his scheduled fire system checks. Any non-compliance will be reported to the Quarterly QAPI Committee for review and revisions where necessary.	