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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2LCP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245183**
2.STATE VENDOR OR MEDICAID NO.
(L2) **531716900**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2014**
6. DATE OF SURVEY **05/09/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **320** (L18)
13.Total Certified Beds **320** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date:
Amy Charais, HFE - NE II — 05/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 06/01/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/03/2018
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

A recertification survey was conducted 2/12/18, through 2/15/18, and complaint investigation(s) were also completed at the time of the standard survey.

At the time of the survey, an investigation of complaint H5183152 was completed and was found to be substantiated at F676 and F725. At the time of the survey, an investigation of complaint H5183153 was substantiated under F609.

On January 10, 2018 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of F.

Lack of verification of compliance with health deficiencies prior to the 70th day requires the following enforcement remedy to be recommended:

Mandatory denial of payment for new Medicare and Medicaid Admissions (DPNA), effective May 15, 2018.

If DPNA goes into effect, the facility would be subject to a two year loss of NATCEP, beginning May 15, 2018.

On May 9, 2018 this department completed a 2nd PCR revisit. The facility was found to be in compliance. We are recommending the following:

- Discontinue the Category 1 remedy of State Monitoring effective April 23, 2018
- Rescind Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 15, 2018.
  -Therefore, the NATCEP prohibition is rescinded

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245183

May 29, 2018

Ms. Diane Willette, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Dear Ms. Willette:

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 April 23, 2018 the above facility is recommended for:

320 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 320 skilled nursing facility beds.

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and 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
May 29, 2018

Ms. Diane Willette, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number

Dear Ms. Willette:

March 6, 2018 we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2018 that included an investigation of complaint numbers H5183152, H5183153. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 30, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring, May 9, 2018.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 15, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 30, 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 May 15, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on February 15, 2018, that included an investigation of complaint numbers H5183152, H5183153, and lack of verification of substantial compliance with the health deficiencies at the time of our April 30, 2018 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 9, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 23, 2018. Based on

our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2018, as of April 23, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 23, 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 April 30, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 15, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 15, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 15, 2018, is to be rescinded.

In our letter of April 30, 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 May 15, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 23, 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 PCR 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: 2LCP

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

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

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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) **01/01/2014**

6. DATE OF SURVEY **04/19/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **320** (L18)
13.Total Certified Beds **320** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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	320			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Amy Charais, HFE - NE II — 05/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 05/31/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/03/2018
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

A recertification survey was conducted 2/12/18, through 2/15/18, and complaint investigation(s) were also completed at the time of the standard survey.

At the time of the survey, an investigation of complaint H5183152 was completed and was found to be substantiated at F676 and F725. At the time of the survey, an investigation of complaint H5183153 was substantiated under F609.

On January 10, 2018 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of F.

Lack of verification of compliance with health deficiencies prior to the 70th day requires the following enforcement remedy to be recommended:

Mandatory denial of payment for new Medicare and Medicaid Admissions (DPNA), effective May 15, 2018.

If DPNA goes into effect, the facility would be subject to a two year loss of NATCEP, beginning May 15, 2018.

Electronically delivered

May 4, 2018

Ms. Diane Willette, Administrator
North Ridge Health and Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Numbers S5183027, H5183152, and H5183153

Dear Ms. Willette:

On March 6, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by Minnesota Department of Health and Public Safety for the standard survey completed on February 15, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 30, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 15, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on February 15, 2018, that included an investigation of complaint numbers H5183152, and H5183153, and lack of compliance at the time of the April 30, 2018 letter. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 19, 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 the survey completed on February 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey completed on February 15, 2018.

At the time of this revisit, we identified the following deficiency:

F0689 -- S/S: D -- 483.25(d)(1)(2) -- Free Of Accident Hazards/Supervision/Devices

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no

actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) , as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of our February 15, 2018 survey findings that your facility is not in substantial compliance, the following Category 1 enforcement remedies will be imposed:

- State Monitoring effective May 9, 2018. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of April 30, 2018

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 15, 2018 remain in effect. (42 CFR 488.417 (b))

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 March 6, 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 May 15, 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

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

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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS 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 August 15, 2018 (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.

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
	245183	A. BUILDING _____ B. WING _____	R-C 04/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments During the original recertification survey exited 2/15/18, there were no deficiencies identified at Appendix Z, Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 4/18/18 - 4/19/18, and found to have NOT corrected all the citations issued on the survey exited 2/15/18. 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. At the time of the standard survey exited 2/15/18, an investigation of complaint H5183152 was found to be substantiated at F676 and F725, and complaint H5183153 was substantiated under F609. Both complaints were found to be corrected at the time of the re-visit.	{F 000}		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	R127 will be assisted per the plan of	4/23/18

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

Electronically Signed | 05/07/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R-C 04/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 review the facility failed to ensure safe transfers for 1 of 1 resident (R127) reviewed for accidents. Findings include: R127's quarterly Minimum Data Set dated 4/6/18, indicated she was moderately cognitively impaired and required extensive assistance from two staff for toileting and transfers. R127's care plan dated 4/12/18, identified an activities of daily living self care deficit related to musculoskeletal impairment, fatigue, limited mobility and pain. The care plan directed to assist with transfers and toileting using two staff. The care plan further identified a risk for falls related to incontinence, abnormal movements and gait/balance problems. During an observation on 4/19/18, at 9:19 a.m. nursing assistant (NA)-A propelled R127 from her room to an alcove across the hall in her wheel chair. NA-A assisted R127 to stand, changed her incontinence brief and sat her back down in the wheel chair. NA-A looked around the curtain, noted surveyor observing and propelled R127 into a tub room. Neither NA-A nor R127 were noted to have a transfer belt. During an interview on 4/19/18, at 9:23 a.m. NA-A stated she had assisted R127 to stand without the assistance of another staff and stated R127 could stand and transfer. NA-A stated she had not used a transfer belt because she had lent hers to another staff member. During an interview on 4/19/18, at 9:30 a.m. the assistant director of nursing (ADON) stated R127's care plan directed staff to transfer and toilet her using two staff members. The ADON further stated transfer belts were mandatory for	F 689	care. Due to the nature of the offense and following the facility disciplinary process the nursing assistant is no longer employed with the facility. Residents will have care delivered per the plan of care. Nursing assistants and licensed nurses have been re-educated regarding following the plan of care when providing services to the residents. DON/designee will audit 15 residents per week for 4 weeks then 15 residents monthly for 2 months for the plan of care being followed during the delivery of service. Cares will include but not limited to transfers, bed mobility, ambulation, and toileting. DON to monitor compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R-C 04/19/2018

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

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F 689	Continued From page 2 all transfers. During an interview on 4/19/18, at 12:05 p.m., the director of nursing stated she expected staff to transfer residents using guidance from the resident's individualized plan of care.	F 689		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2LCP

Facility ID: 00238

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2014**

6. DATE OF SURVEY **02/15/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	320			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christine Giancola, HFE NE II 03/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 04/03/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

A recertification survey was conducted 2/12/18, through 2/15/18, and complaint investigation(s) were also completed at the time of the standard survey.

At the time of the survey, an investigation of complaint H5183152 was completed and was found to be substantiated at F676 and F725. At the time of the survey, an investigation of complaint H5183153 was substantiated under F609.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2018

Ms. Diane Willette, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Numbers S5183027, H5183152, H5183153

Dear Ms. Willette:

On February 15, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5183152 and H5183153 that were found to be substantiated.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 27, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 27, 2018 the following remedy will be imposed:

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

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 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as

mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory 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 mandatory 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 August 15, 2018 (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 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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 02/15/2018

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

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 2/12/18 through 2/15/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 2/12/18, through 2/15/18, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint H5183152 was completed and was found to be substantiated at F676 and F725. At the time of the survey, an investigation of complaint H5183153 was substantiated under F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		3/27/18

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

Electronically Signed | 03/16/2018

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F 550	Continued From page 1 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 550		

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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure visual privacy for 1 of 1 resident (R94) reviewed for urinary catheter, failed to ensure 1 of 1 resident (R157) was dressed in a dignified manner, and failed to provide a dignified dining experience for 1 of 1 resident (R42). Findings include R94's quarterly Minimum Data Set (MDS) dated 12/15/17, indicated intact cognition and a diagnosis of neurogenic bladder with a catheter. R94's Order Summary Report printed 2/23/18, identified an order dated 3/11/16, that instructed staff to cover the catheter bag and leg bag every shift. R94 was interviewed on 2/13/18, at 8:45 a.m. lying in bed. R94's urinary catheter bag was attached to the right side of the bed facing the door. The urinary catheter bag was not covered and there was urine in the bag. On 2/14/18, at 9:41 a.m. nursing assistant (NA)-G brought a breakfast tray to R94's room. The catheter drainage bag hung on right side of the bed. The bag contained 200 cubic centimeters (cc) of orange cloudy urine with sediment visible. The urinary catheter bag was not covered. At 10:11 a.m. NA-G removed the tray from room. The catheter drainage bag hung on right side of the bed with no privacy cover. Approximately 250cc of urine was visible in catheter bag. On 2/15/18, at 11:08 a.m. the urinary catheter bag	F 550	R94 catheter bag was replaced with a fig leaf type bag which includes privacy cover as part of the catheter bag. R157 has discharged from the facility. Staff will communicate with R42 when assisting resident with eating. Residents with a catheter will have dignity and privacy maintained with use of fig leaf type catheter bag. Residents clothing will be labeled with labels affixed in a private area. Staff is expected to communicate with residents when assisting with eating. Staff was provided education regarding resident rights including maintaining dignity and communicated with residents when providing assistance. DON/designee will complete audits of 10 residents per week for a month, then monthly for 2 months. Audit will include areas of concern noted for privacy and dignity. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 550	Continued From page 3	F 550		

was again visible on the right side of R94's bed with 400 cc of red-yellow, cloudy urine. R94 acknowledged there was no cover over the drainage bag.

During interview on 2/15/18, at 11:23 a.m. trained medication aide (TMA)-A stated catheter drainage bags should be covered at all times to maintain privacy.

During an interview on 2/15/18, at 11:27 a.m. NA-D stated catheter drainage bags should be kept in a privacy bag so others do not see the urine. NA-D stated it would not be very appealing.

During interview on 2/15/18, at 12:06 p.m. registered nurse (RN)-G stated the facility did not cover catheter bags in bed, only in the wheel chair. RN-G stated, "The reason we do not cover it [catheter bag] in bed is because some staff may say they do not see it."

During interview on 2/15/18, at 2:00 p.m. the director of nursing (DON) stated the bed urine collection bags were a self covered bag called a Fig Leaf. The DON stated if the collection bag was not a Fig Leaf bag then the urinary collection bag should be in a privacy bag so it wasn't possible to see the urine. R94 did not have a self covering drainage bag.

R157's care plan dated 1/3/18, identified a self care deficit and directed staff to assist with dressing and grooming. The admission Minimum Data Set dated 1/10/18, indicated R157 required extensive assistance with dressing and was severely cognitively impaired.

During observation on 2/12/18, at 1:54 p.m.,

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F 550	Continued From page 4 R157 was lying on top of his bed. R157 was wearing a pair of red socks. Affixed to the top of the socks were white labels, approximately ¾ inch wide by 3 inches long, with R157's first and last name in black print. On 2/14/18, at 8:38 a.m., R157 was again observed lying on top of his bed wearing the red socks with the white labels displaying his name. During an interview on 2/24/18, at 9:40 a.m., the director of nursing said she expected residents to be clothed without names visible anywhere on the clothing. The undated facility Resident Personal clothing policy stated "All clothing for all residents in the long term care facility must be labeled in a manner that is both practical and respects the dignity of the resident." R42's Order summary dated 2/15/18, noted R42 had an order for a pureed diet with thin liquids. The care plan last reviewed 12/3/17, indicated R42 was legally blind and needed assistance to eat. A Care Area Assessment dated 6/13/17, for communication indicated R42 had a history of unclear speech During continuous observation on 2/14/18, from 9:05 a.m. to 9:34 a.m. R42 was sitting in a wheelchair at a table in the dining room. R42 swept an arm across the top of the table to find a cup to drink from. Without speaking to R42, NA-I gave R42 a covered cup of milk, and picked the tray up from the table and left the dining room. At	F 550		

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9:14 a.m. NA-I returned to the table with a different tray of food. Without speaking to R42, NA-I tucked a napkin into the neck of R42's shirt and stated it was time to eat. NA-I began talking to another NA (unidentified) seated across the table. NA-I and the other NA were discussing vacation hours. When R42 had emptied her cup, NA-I picked up the cup and left the table without speaking to R42. NA-I returned after a couple of minutes with the cup filled with milk. NA-I still did not speak to R42 upon returning to the table or during the remainder of the meal.

On 2/15/18, during continuous observation from 9:01 a.m. to 9:17 a.m. R42 was seen sitting at a table in the dining room with nothing in front of her. Every couple of minutes R42 would sweep her arm over the table top to feel for any objects. At 9:09 a.m. nursing assistant (NA)-A brought a tray of food and sat down at the table in front of R42. NA-A did not speak to the R42. At 9:17 a.m. R42 began coughing after each drink of juice. NA-A did not speak to R42, but did inform registered nurse (RN)- E about R42's coughing. Neither NA-A or RN-E spoke to R42 or explained what was happening as R42 was wheeled away from the table and taken out of the dining room.

At 9:44 a.m. NA-A stated staff is expected to talk to the resident's during meals so the resident knows what care is being provided. When asked about dementia training NA-A indicated it was done on the computer and nursing staff had a dementia computer class approximately every 2 months.

On 2/15/18, at 3:29 p.m. the director of nursing stated she expected staff to speak to the residents during meals and not talk to each other

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F 550	Continued From page 6 unless it was about a resident.	F 550		
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 the process to determine self administration of medications and storage of medications was followed for 1 of 1 resident (R210), who was self administering and storing medication. Findings include: On 2/12/18, at 7:00 p.m. a card of medication was observed on the table next to the door of R210's room. R210 stated the medication was Sevelamer (Sevelamer was used to bind the phosphorus in R210's blood) and indicated R210 was required to take the Sevelamer with meals. R210 explained that because of eating at odd times the medication was stored in R210's room and R210 self administered the medications. On 2/15/18, at 12:49 p.m. R210 stated the card of Sevelamer is placed in the drawer of the nightstand. R210 stated the drawer did not have a lock on it and responded, "I suppose I should keep the medications in the locked drawer." R210 stated that Occupational Therapy (OT) had done the self administration of medications assessment. The card of Sevelamer was sitting on the table next to the door.	F 554	R210 has a locked box in room to store medication. Self administration assessment was completed on resident, physician order was obtained, and care plan was updated to reflect resident□s ability to self-administer medication. Residents have the right to self-administer medications if determined appropriate. Interdisciplinary team will review residents for desire and ability to self-administer. Review will be completed upon admission and quarterly. Licensed nurses were provided education regarding resident□s rights to self-administer medication and process to be completed including self-administration assessment, physician order, updating the care plan, and medication being secured in resident□s room if desired. DON/designee will audit 5 residents who self-administer medication per week for a month, then monthly for 2 months. Audit will include assessment, physician order, care plan accuracy, and appropriate storage of medication. Results of the	3/27/18

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F 554	Continued From page 7 R210's Admission Record dated 2/15/18 indicated R210 had stage 5 kidney disease and dependence on kidney dialysis. The Care Area Assessment (CAA) dated 8/3/17 revealed no assessment for self administration of medications. The OT Discharge Summary dated 11/15/17, did not note any assessment for self administration of medication. The Order Summary Report dated 2/23/18 indicated no physician order for self administration of medication. R210's care plan last reviewed on 1/29/18, revealed a self administration of medications problem initiated on 2/12/18, with an intervention of a locked box in R210's room to store the medication in. On 2/15/18, at 3:29 p.m. the director of nursing (DON) stated it was expected any resident that self administers medication needed to have a self administration of medication assessment, a physician's order for self administration of medications, and a locked drawer of box to store the medications in.	F 554	audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 558	R485 has discharged from the facility.	3/27/18

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F 558	Continued From page 8 review, the facility failed to ensure call lights were accessible for 1 of 1 resident (R485) who had vision impairment and capable of using the call light reviewed for environment. Findings include: R485, on 2/12/18, at 12:13 p.m. was observed lying in bed. When approached and asked how he was doing resident stated was, "well." Resident asked surveyor to read a scroll message he had received from a friend. The call light was observed clipped on the chair which was two feet from the bed. Resident stated he was legally bed and needed his call light by him. At 12:21 p.m. licensed practical nurse (LPN)-C went to room with surveyor and verified the call light was not at reach, "he would not reach or be able to get it." LPN-C moved the call light and R485 stated staff had not given it to him when they changed his bedding that morning. R485 further stated he used the call light because of poor vision. LPN-C also stated nursing assistants (NA) were supposed to make sure the call light was in reach. On 2/13/18, at 9:17 a.m. during a random observation R485 was observed lying in bed and the call light cord was observed hanging behind the head of the bed. When asked if he was able to reach it, R485 stated he was not able to see well and needed the call light to call for assistance. R485's care plan dated 1/30/18, identified resident was at risk for falls due to confusion , gait/balance problems, incontinence, and vision/hearing problems. The care plan directed staff to ensure the call light was within reach and	F 558	Residents with vision impairment will have call light placed in an accessible location. Staff was educated that call lights must be kept in accessible location for the resident□s ability to call for assistance. DON/designee will audit placement of call light for 10 residents weekly for a month then monthly for 2 months. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 558	Continued From page 9 encourage R485 to use it for assistance as needed and R485 needed prompt response to all requests for assistance. On 2/14/18, at 3:35 p.m. the director of nursing stated she would expect all call lights to be within reach for residents who were able to use them.	F 558		
F 565 SS=E	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. (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.	F 565		3/27/18

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F 565	Continued From page 10 §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 interview and document review, the facility failed to effectively respond to resident council grievances related to staffing patterns and call light response times, for 9 of 9 resident council members (R94, R44, R169, R216, R60, R30, R99, R116, R124) present during the resident council meeting with survey team. Findings include: Review of Resident Council meeting minutes from 10/16/17, to 1/22/18, identified the following: -10/16/17 meeting minutes dated identified a resident complained about nursing assistants (NA) rolling their eyes and/ or walked by when residents called on them. Also indicated residents did not want to ask for help because they did not want to be a burden. During this meeting another resident stated their call light had been turned off three times without being asked about their needs. -11/20/17 meeting minutes identified concerns expressed regarding staffing on TCU (Transitional Care Unit) with one NA and one float per hallway; NA's were available to help during meals, however, other staff persons would answer call lights and turn the lights off telling residents, "I'll tell your aide. -12/11/17 meeting minutes identified the residents brought up that the food warming trays were not working in 2 West and TCU and food was cold.	F 565	Grievances for food concerns were completed for voiced concerns by R99, R94, R30, R116. Grievances for respect & dignity concerns voiced by R116 & R216 were completed. Grievances were communicated for call light concerns voiced by R216, R99, R94, R30. Residents R94, R44, R216, R60, R30, R99, R116, and R124 will be provided with follow up information within policy time frame. Resident Council Minutes will be reviewed for grievances. Recreation department and leadership team have been trained on resident council concern process. Policy and procedure reviewed and revised. Recreation Director and/or Designee will maintain and monitor resident council concern process for effective response to council grievances bi-weekly for three months; response will be reflected in resident council minutes. Audit results will be reviewed and shared at QAPI for frequency, duration, and effectiveness. Administrator to monitor for compliance.	

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-1/22/18 meeting minutes identified the food warming trays were brought up again. The report indicated NA's were serving multiple trays and by the time the food got to the resident it was cold. The meeting minutes indicated nutrition service was going to encourage the NA's to make up one tray at a time. In addition, at this meeting, several residents brought up the concern of call lights and the administrator stated she would have the nurse manager individually see the residents who had concerns.

Despite the same concerns being brought up during the meetings the facility failed to follow up, resolve grievances and/or give a reasonable explanation for the issues brought up.

On 2/13/18, at 3:34 p.m. to 4:25 p.m. the resident council meeting was attended by R94, R44, R169, R216, R60, R30, R99, R116, R124 and surveyors.

When asked if the facility considered the views of the resident group and acted promptly upon grievances and recommendations R216 stated, "grievances; they address the grievances but they don't ever get fixed. It depends on the aide. I need help but I don't get it. I have fallen so many times I am going back to therapy. My body is covered in black and blue. They should have better control over the aides. I had the call light on for more than an hour and a half this morning. A lot of them will deny a lot of things. I had an incident yesterday in the dining room. I came late for dinner. I was having a shower; my table mates had their meal and I had to wait for a long time and left the dining room and went back to my room and they brought the meal in the room and I refused to eat it. They will take a long time before

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they wait on you and just stand there and we have told them about this." R99 verified R216 had to wait for a long time and staff had gone past R216. Residents brought up the concern about food being served cold and not the right temperature which had been brought up during previous council meetings and had not been addressed. When asked how the evening meal was the previous evening R99 stated "I had cold beef. I mean ice cold beef, they ran out of food; the bun was so cold I took it off." R94 asked, "why do they run out of food" and R30 stated, "I got used to eating cold food. I thought it was the law that we got warm food. I never stayed anyplace where they told me they did not have food."

When asked about grievances being addressed promptly R216 stated "They say we will look into it like the check is in the mail. They talk about the food at the food council but nothing happens." R94 stated the facility management would say, "We're looking into it. we are working on it." R116 and R99 stated regarding the cold food concern they had found out the facility did not have a stove to warm the food as the food was cold all the time and the plates were cold. Residents thought the facility needed to pay attention to ensure it is hot. R30 also stated "We do not get the condiments we need all the time, we do not have shakers, we get packets if you ask." R94 stated "there was no salt, pepper and butter for baked potatoes. They do not bring the butter until food is cold." R99 also stated "when they have salad they only have ranch dressing. They should have a place where we can put things we do not use. These are some of the things we have brought up about food and food service.

When the residents were asked if they knew how

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to file a grievance, R216 stated "Filling out grievances does not do any good. They do not follow up with us after we write a grievance."

When asked if the resident group could bring up concerns about care, the residents present reported that there is fear of retaliation for making concerns known. Residents stated staff were rude and at times, would ignore them and not wait on residents if they were out spoken. R216 stated this continued to happen and made her mad.

When residents were asked about the help/care needed and if staff responded to the call lights timely, R216, R99, R94, and R30 stated when the call lights are put on, it takes a long time and eventually when staff come to the room, it might be too late. Residents reported staff did not come when they had to go to the bathroom. All residents present unanimously agreed the call lights were not answered and when staff do come to the rooms, the call lights are turned off and staff say they will be back but they do not come back. When asked about responding to bathroom call lights the residents reported the staff do not answer the call light in the bathroom any different. R60 appeared upset and stated, "I had a nose bleed this morning 12/13/18, and had to wait half an hour. I was bleeding out of my nose and it got on the floor and the clothes. It took a long time." R216 stated her family member had also brought up concerns about the length of time it takes for call lights to be answered. R216 stated, "They think they have enough staff, they don't, but they think they do."

When residents were asked if staff treated them with respect and dignity, five of nine residents

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stated they do not feel nursing assistants treat them with respect and dignity all the time and that this had been communicated to the facility management staff but nothing has happened. R116 stated the nursing assistants were out of control. R216 further stated, "Everything is written on paper but nothing gets done."

On 2/15/18, at 2:48 p.m. the administrator and the director of activities were interviewed. Both indicated when the concerns regarding call lights and other resident care needs had been brought up at the monthly council meetings they thought the former director of nursing had addressed them as he had stated he was going to do training. When asked if grievances were completed for residents concerns the activity director stated she e-mails the department heads and lets them know of the concerns and assumes the issues are communicated and addressed. She further stated she would invite the department heads to the next council meetings to address the issues identified. When all the concerns were reviewed from the resident council meeting minutes and resident council meeting held on 2/13/18, the administrator stated the facility had tried something new each time but did not know if it was working and had not gone back to the residents to follow up. The administrator stated a follow up was being done but there was no "paper trail with all the issues that the residents had brought up." The administrator acknowledged there was not enough being documented about what had been done and that follow up had not been completed to make sure what had been put in place was working. When asked about residents feeling retaliated about reporting care concern complaints, the administrator stated staff were not supposed to

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F 565	Continued From page 15 retaliate against residents, "We don't tolerate that here." The facility Filing Grievances/Complaint policy revised November 2016, indicated: 3. Grievances and/or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the resident or the person filing the grievances or complaint on behalf of the resident. The "grievances official" must maintain the confidentially for residents whose grievance is submitted anonymously... 5. Upon receipt of a grievance and/or complaint, the grievances official" will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The "grievance official" will also give a written grievance decision to the resident. 6. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken..."	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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	F 580		3/27/18

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F 580	Continued From page 16 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §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:	F 580		

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F 580	Continued From page 17 Based on observation, interview, and document review the facility failed to ensure the physician was notified of a nose bleed for 1 of 1 resident (R60) reviewed notification of change. The findings include: R60's diagnoses included anemia, tachycardia, history of falling, muscle weakness, abnormal gait and mobility obtained from the quarterly Minimum Data Set (MDS) dated 12/1/17. Resident care plan dated 3/2/18, indicated resident was at risk for falls and had head injury 8/2/17. The care plan directed staff to be sure the resident's call light was within reach, encourage to use it for assistance as needed. Staff anticipate all residents needs. On 2/13/18, at 4:10 p.m. during the resident council meeting R60 stated, "I had a nose bleed this morning." Review of the nursing notes, 2/13/18, at 12:53 p.m., identified "Resident had a little nose bleed this morning and later stopped. Staff cleaned and reduced heat in resident's room. Reassessed, no nose bleed noted/reported. Vital signs (VS) included blood pressure 122/64, temperature 97.8, pulse 76, respirations 18, and oxygen saturation 97% at room air (RA). The nurse indicated the staff were notified and the 24 hour board was updated for monitoring. The medical record lacked documentation the nurse practitioner (NP) or medical doctor (MD) and family/responsible party had been notified of the nose bleed. On 2/15/18, at 12:09 p.m. the director of nursing stated she would expect the nurse to let the doctor know the next day and if it was bad would call immediately.	F 580	R60 had a nosebleed noted on 2/13/18. Staff stopped bleeding and vital signs were checked. Resident had no ill effect from nosebleed. NP has been updated regarding nosebleed. Current residents with a change in condition/treatment will have appropriate and timely notification of those changes to the NP. Licensed nurses have been re-educated regarding notification of change of condition and facility policy regarding notifying practitioners of changes in condition. DON/Designee will audit up to 5 changes in condition weekly for 4 weeks then monthly for 2 months to ensure compliance with policy. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 580	Continued From page 18 On 2/15/18, at 12:50 p.m. licensed practical nurse (LPN)-E verified on 2/13/18, morning shift R60 had a nose bleed which she heard was a lot as it was on the sheets, floor and clothes. LPN-E stated on 2/13/18, she was not assigned to R60 but knew from working with R60 before resident had a history of nose bleeds and Aspirin had been discontinued last year. LPN further stated the nursing assistant (NA)-H who had worked and assisted R60 on 2/13/18, was in the unit. At 12:56 p.m. LPN-E approached and stated she had looked at the notes and did not understand the reason the nurse had documented was "a small noise bleed." Interview with NA-H at 1:00, reported when he got to the room R60 had a nose bleed there was a lot of blood as R60 was leaning forward. NA-H stated he had to stay with resident for over 20 minutes applying pressure and a cold pack before the nose bleed stopped. On 2/15/18, at 1:11 p.m. registered nurse (RN)-C stated he would expected the nurse to have documented accurately and notify the provider. RN-C stated this was the first time he had heard about the nose bleed. He reviewed the medical record and verified there was no documentation of the NP/MD being notified and the responsible party. RN-C further reported that based on the information and collaboration from other staff, the doctor should have been notified.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		3/27/18

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F 584	Continued From page 19 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a clean	F 584	Wall of R82 was repaired on 2/15/18. R82 photo collage was repaired to	

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F 584	Continued From page 20 homelike environment for 1 of 1 resident (R82). Findings include: On 2/12/18, 5:11 p.m. during observations of the facility, a hole approximately 3 inches by 1 inch was seen in the wall behind R82's room door. The hole went through the full thickness of the sheetrock and was located at the level of the door handle and in the shape of the door handle. On 2/14/18, 1:10 p.m. the hole remained in the wall, however, there was a picture collage board covering the hole in the wall. On the collage, at the level of the door handle, there was a hole through the picture. The hole in the collage lined up with the hole in the wall. At 1:22 p.m. registered nurse (RN)-F was shown the hole and was asked what the procedure was for reporting maintenance issues. RN-F removed the picture board off the wall and stated a work order would be submitted to maintenance to repair the hole in the wall. On 2/15/18, at 8:55 a.m. the hole remained in the wall of R82's room. At 12:27 p.m. the Adminstrator stated the procedure for submitting a work order is electronic. Staff are taught how to submit a work order at new hire, orientation and annually. If there was an urgent need the maintenance employees carried walkie talkies for communication. In regard to the damage of the resident's collage picture, the Administrator stated usually it was discussed in morning report and the facility would attempt to repair or replace the damaged item if it was related to staff action. In addition the Administrator expected staff to notify a supervisor. The Administrator had not been notified of the damage to R82's picture collage.	F 584	resident and family satisfaction on 2/16/18. Family will make decision of homelike environment in where to rehang picture. Resident□s rooms will be observed for needed repairs and corrected in a timely manner. Staff educated on reporting of repairs or physical plant needs through use of electronic TELS reporting system. Director of Housekeeping and/or Designee will conduct resident room audits weekly for one month and then monthly for two months to monitor safe, clean, comfortable homelike environment. Administrator to monitor for compliance	

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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 observation, interview, and document review the facility failed to investigate and report allegations of mistreatment to the state agency (SA) for 2 of 8 residents (R129, R49). Findings include:	F 609	R24 immediately moved to another unit in the facility to prevent reoccurrence of incident with R129 (R24 has discharged facility); incident reported to state agency. Allegation involving R49 reported to state agency.	3/27/18

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F 609	Continued From page 22 R129 had an incident with another resident which was not reported or investigated as abuse. R129 had a quarterly minimum data set (MDS) assessment dated 12/22/17 indicating severe cognitive disability, A care area assessment (CAA) dated 3/31/17 identified R129 had a recent mood decline and confusion related to sepsis. The care plan dated 3/10/17 indicated R129 had impaired cognitive function/dementia, impaired thought processes related to impaired thinking. The care plan indicated that R129 was vulnerable due to cognitive deficits. R129 had diagnoses including metabolic encephalopathy, major depression, anxiety, and resided on the secured dementia unit. A progress note by RN-D dated 2/10/18 at 7:10 p.m. indicated R129 was found in another resident's room unclothed and laying on back with legs on the bed. Another resident, R24, was standing above R129 looking down at her. RN-D was interviewed on 2/14/18 at 8:49 a.m. regarding the incident and stated being new to the unit and had worked the evening shift 2/10/18 on the secured dementia unit. She stated R129 and R24 were found in a third resident's room on a hallway away from where their rooms were located. She stated an aide went to the room and immediately called her into the room to check on the residents. RN-D stated R24 was fully clothed and R129 was unclothed, lying on the floor with a wedge cushion under buttocks. Both residents denied touching had occurred. RN-D stated R129 was not upset or injured and R129 had stated, "we are just trying to get out of here". RN-D stated she called the supervisor and the supervisor called the director of nursing (DON). She said no report was made to the SA	F 609	Facility will identify other residents through resident and family council, the grievance process, and incidents of concern voiced by staff, residents, and family members. Staff educated on vulnerable adult reporting and who to report suspected abuse to; all staff are mandated reporters. Education provided to staff regarding using the gender pronoun of the resident□s preference. Director of Nursing and/or Designee will monitor for suspected abuse and vulnerable adult reporting in reviewing grievances and 24-hr report documentation. Administrator to monitor for compliance.	

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because R129 said she felt safe, When asked if R129 could undress herself RN-D stated R129 could unbutton and pull down pants, but could not undress. She stated both R129 and R24 were on 15 minute checks at the time of the incident.

During an interview on 2/14/18 at 2:40 p.m. the director of social services stated she was familiar with R129 and had completed her cognitive assessment, brief inventory of mental status (BIMS) with a score of 6 with moderated confusion. She stated R129's cognitive function varied and had been confused the past couple of weeks due to medical issues. She stated R129 would have difficulty reliably reporting events.

During an interview on 12/14/18 at 2:45 p.m. with social service assistant, R24 was very confused and not able to answer questions reliably. R24 had an admission assessment MDS dated 11/14/18 and had a diagnosis of dementia with behaviors and was unable to complete the BIMS screening.

The DON was interviewed at 10:30 a.m. on 2/14/17 and stated she had worked at the facility for 3 weeks and had been trained in abuse/neglect and reporting to the SA. She defined resident to resident sexual abuse as non-consensual when it was unwanted and they would know with a dementia resident if they said no or pushed person away. She stated she remembered being called on 2/10/18 at 7:49 p.m. and the event was reported to her, she was not sure about a report to the SA so asked the supervisor to contact the assistant administrator.

During an interview with the assistant administrator on 2/14/18 at 10:50 a.m., she

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verified being called on 2/10/18 about the incident and reported that she thought R129 was in her room and was not aware of how R129 was positioned. She had asked the evening supervisor if the DON had been notified, and did not report the incident because R129 felt safe. She stated the policy for resident to resident was clear and a report would have been made if she knew all of the circumstances.

The administrator was interviewed on 2/14/18 at 12:40 p.m. and stated a reportable incident would be sexual contact, physical contact, but each individual would be different. She stated being notified 2/10/18 by phone that a male resident was in a female resident's room. She stated she did not report to the SA based on no harm, no touching, and R129 was not fearful. She stated that the team discussed it at a meeting Monday morning, but she did not have any additional information. Would report any touching - non-consent. When the circumstances of the incident were reviewed, the administrator stated- "I probably would have reported." On 2/14/18 at 3:00 p.m. the incident report dated 2/10/18 was further discussed with the administrator. The administrator she stated it should have been immediately reported on 2/10/18 and an investigation started. The administrator reported that R24 had been moved to a different unit on 2/12/18 and had constant supervision.

The facility policy titled "Reporting of Abuse Allegations" dated 8/2016 indicated that allegations of abuse should be reported to the state agency within 2 hours. The policy titled: Reporting Abuse to Facility Management, dated 11/17, defines sexual abuse as non-consensual contact of any type with a resident.

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Non-consensual behavior includes any behavior that may want the contact to occur but lack the cognitive ability to consent. A policy for resident to resident altercations was requested but not received.

R49's admission Minimum Data Set (MDS) dated 11/2/17, identified R49 was cognitively intact with diagnosis of Parkinson and transsexualism.

During interview on 2/13/18, at 9:23 a.m. R49 stated she had been verbally abused by staff. R49 said, "They keep referring to me with male pronouns. I am not a guy. It makes me very angry. I think they do it deliberately but they will say they forgot. I do not want to deal with any men. They bully me." R49 stated she had let the social worker know about the verbal abuse and said she felt the issue was deliberate. R49 was sitting in bed, looking down, facial expression flat but voice intense while voicing her concerns.

On 2/14/18, at 1:38 p.m. R49 stated the short male staff member who worked on the unit in the afternoon often called her a guy. R49 stated staff were aware that she found that abusive and emotionally distressing.

On 2/15/18 at 9:55 a.m. surveyor reviewed facility list of reports to state agency in the last six months. There were no reports of verbal or emotional abuse toward R49.

On 2/15/18, at 10:01 a.m. Social worker (SW)-A, director of social service, stated R49's social worker left the week prior. SW-A stated she had not heard of any allegations from R49 of staff deliberately calling her by the pronoun him or male. SW-A stated if R49 had told me, I would

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F 609	Continued From page 26 consider this verbal and emotional abuse. On 2/15/18, at 10:14 a.m. administrator and director of nurses (DON) verified there were no reports made to the state agency for verbal or emotional abuse for R49. Surveyor informed administrator of R49's allegation of ongoing verbal and emotional abuse. On 2/15/18, at 2:05 p.m. the DON stated the report of possible verbal abuse toward R49 was made to the state agency on 2/15/18 at 1:37 p.m. The DON stated the time frame for reporting an allegation of abuse, if no injury 24 hours, if an injury within 2 hours.	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		3/27/18

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F 623	Continued From page 27 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 28 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R136) or legal representative were provided a notice of transfer to hospital. In addition, failed to send the	F 623	R136, R258, R53, R206, R198, and R263 were admitted back to the facility. Bed hold policy will be provided to each resident / family representative / guardian.	

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F 623	Continued From page 29 notice to the long term care ombudsman when practicable for 1 of 1 resident (R136) reviewed for hospitalization. Findings include: R136's diagnoses included chronic respiratory failure with hypercapnia, hypoxic ischemic encephalopathy, hemiplegia and hemiparesis, encounter for attention to tracheostomy, muscle weakness (generalized), quadriplegia, obstructive sleep apnea, immobility syndrome (paraplegic) obtained from the 30 day Minimum Data Set (MDS) dated 1/22/18. In addition, the MDS indicated resident had severely impaired cognition. On 2/12/18, at 6:32 p.m. when asked if R136 had recently been hospitalized, family member stated R136 had been to the hospital for a few days at the end of December 2017. Family member stated staff had contacted her about the hospital transfer however no notices were discussed or provided. During review of the Interdisciplinary team (IDT) notes, it was revealed on 12/20/18, R136 had been sent to the hospital due to oxygen saturation level dropping despite respiratory therapy interventions. In addition, the note indicated family member had been updated and verbalized understanding. During further review of the IDT notes it was revealed, R136 was readmitted to the facility on 12/27/17, with a diagnoses of acute Bronchitis. The medical record lacked documentation for the hospital transfer in writing and in a language and manner resident/representative understood and facility did not send a copy of the notice to a representative	F 623	Bed hold policy reviewed, procedure clarified, and staff reeducated on appropriate process to prevent future reoccurrence of deficient practice. Director of Social Service and/or Designee will audit bed hold procedure weekly for one month, then monthly for two months to ensure compliance. Audit results will be reviewed at QAPI for frequency, duration, and effectiveness. Director of Social Service to monitor for compliance.	

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F 623	Continued From page 30 of the Office of the State Long-Term Care Ombudsman. On 2/14/18, at 1:19 p.m. registered nurse (RN)-I reviewed the IDT notes and verified there was no documentation provided/offered for the hospital transfer to resident representative. RN-I stated he was not sure where the staff documented information on bed hold notice. On 2/14/18, at 8:44 a.m. the director of social service (DSS) stated the director of business development in admissions would be the person to ask about the notices provided to R136. The DSS verified the IDT notes lacked documentation R136 representative had been provided a transfer notice prior to being transferred to the hospital. On 2/14/18, at 9:17 a.m. the director of business development stated nursing was supposed to provide the notice when transferring the resident to the hospital. On 2/14/18, at 1:38 p.m. the licensed social worker (LWS)-C stated following a hospital transfer the social worker assistant would notify the family and would send an e-mail to the nurse manager and her. LSW-C verified there had been contact with R136's family member about resident being sent to the hospital but no transfer notice had been discussed. LWS-C directed surveyor the director of business development and the social worker assistant as she did not know if there was a paper provided to the resident/representative and was not sure if staff was supposed to document in the medical record.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		3/27/18

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F 625	Continued From page 31 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 6 of 6 residents (R136, R258, R53, R206, R198, R263) or legal representatives had been informed of bed hold rights at the time of hospitalizations. Findings include:	F 625	R136, R258, R53, R206, R198, and R263 were admitted back to the facility. Bed hold policy will be provided to each resident / family representative / guardian. Bed hold policy reviewed, procedure clarified, and staff reeducated on appropriate process to prevent future	

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F 625	Continued From page 32 R136's care plan dated 1/9/18, identified the need for assistance with all decision making. R136's 30 day Minimum Data Set (MDS) dated 1/22/18 indicated R36 had severely impaired cognition. During an interview on 2/12/18, at 6:32 p.m. family member (FM)-A stated R136 had been to the hospital for a few days at the end of December 2017. FM-A stated staff had contacted her about the hospital transfer however no notices were discussed or provided. A review of the Interdisciplinary team (IDT) notes, indicated on 12/20/18, R136 had been sent to the hospital. The note indicated a family member had been updated and verbalized understanding. Further review of the IDT notes indicated R136 was readmitted to the facility on 12/27/17. The medical record lacked evidence of the hospital transfer. In addition, facility did not send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. On 2/14/18, at 1:19 p.m. registered nurse (RN)-I reviewed the IDT notes and verified there was no documentation a bed hold notice and a hospital transfer instructions had been offered/provided to R136's representative. RN-I stated he was not sure where the staff documented information on bed hold notice. R258's quarterly MDS dated 2/2/18, indicated he was moderately cognitively impaired. On 2/12/18, at 6:07 p.m., R258 stated he had been hospitalized approximately four months ago. Review of R258's Progress Notes dated 11/17/17, indicated R258 had been sent to the hospital. The	F 625	reoccurrence of deficient practice. Director of Social Service and/or Designee will audit bed hold procedure weekly for one month, then monthly for two months to ensure compliance. Audit results will be reviewed at QAPI for frequency, duration, and effectiveness. Director of Social Service to monitor for compliance.	

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F 625	Continued From page 33 Progress note lacked documentation indicating a bed hold notice had been provided prior to transfer. On 2/14/18, at 8:44 a.m. the director of social service (DSS) stated at the time of R136's hospital transfer "we had the assistant social worker who was doing a tracking system for the bed hold notice." The DSS also stated the director of business development in admission would be the person to ask about the notices provided for R136. The DSS verified the IDT notes lacked documentation R258 and R136 had been provided bed hold notices at the time residents were transferred to the hospital. DSS stated R258 was his own responsible party and acknowledged residents were supposed to be given a bed hold notice. On 2/14/18, at 9:17 a.m. the director of business development stated the the Bed Hold Admission Agreement directed staff to provide a bed hold notice at the time of the hospital stay. On 2/14/18, at 1:38 p.m. the licensed social worker (LSW)-C stated if a resident was their own responsible party the assistant social worker would notify the director of business development who would visit them in the hospital to check if they were a bed hold or not. When asked where the social worker assistant documented, LSW-C stated she was not sure. LSW-C stated the social worker assistant would notify the family if a resident was unable to make decisions and would send an e-mail to the nurse manager her about the bed hold. LSW-C verified there had been contact with 136's family member about R136 being sent to the hospital but no bed hold notice had been discussed.	F 625		

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F 625	Continued From page 34 On 2/15/18, at 11:28 a.m. DSS stated it had not been clear who was responsible for issuing the bed hold notices and indicated moving forward, social services would take responsibility to ensure it was being done. The DSS stated the notices were not being given.. R53's Admission Record printed 2/15/18, indicated R53 had been hospitalized from 12/20/17 through 12/22/17. The Admission Record further indicated R53 was his own responsible party. The quarterly Minimum Data Set (MDS) indicated R53 was cognitively intact. A hospital discharge summary dated 12/22/17, identified R53 had been hospitalized from 12/20/17 through 12/22/17, with an acute condition. R53 had been sent to the hospital emergency room from a clinic appointment. R53's medical record lacked evidence that a bed hold policy notification/decision was provided to R53 during the hospitalization. During interview, on 2/13/18, at 10:23 a.m. R53 stated he had been in the hospital for 2 days and did not remember receiving a bed hold notification. On 2/15/18, at 10:29 a.m. registered nurse (RN)-A stated he did not remember R53 getting a paper notification of the bed hold policy notification/decision form. RN-A stated the social worker would have taken care of that. On 2/15/18, at 10:37 a.m. social worker (SW)-A stated she did not know if he received a bed hold policy notification/decision form. SW-A stated if a resident goes to the hospital, they talk about it the next day and the admissions personnel would	F 625		

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follow up with the bed hold. SW-A stated they do not always send one with the resident when they go to the hospital.

On 2/15/18, at 11:03 a.m. SW-A verified they did not have bed holds for R53.

On 2/15/18, at 11:05 a.m. director of nursing (DON) stated it was her expectation to make a call to the family or inform the resident, and ask about the decision for bed hold. DON stated a bed hold form should have been delivered to R53 at the hospital.

R198's quarterly Minimum Data Sheet (MDS) dated 1/14/18, indicated she had intact cognition.

During an interview on 2/12/18, at 5:02 p.m., R198 stated she had been hospitalized about four months ago and had not been informed of the facility bed hold policy.

R263's annual Minimum Data Set (MDS) dated 1/24/18, indicated he was cognitively intact. Review of R263's progress notes indicated he was sent to the emergency room on 12/23/17 and 1/7/18.

During an interview on 2/15/18, 12:27 p.m., with Director of Social Services stated was not sure if R198 or R263 received a written copy of the bed hold policy. Director of Social Services indicated the facility had two different staff members in charge of the issuing the bed hold and it would depend on who did it and if it was documented.

During an interview on 2/15/18, 12:29 p.m., Director of Social Services indicated staff was trying to determine if R198 and R263 received a

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bed hold notice upon discharge to the hospital and would let surveyor know.

By the end of the day on 2/15/18, facility was unable to provide evidence R198 or R263 received a bed hold notice at the time of hospitalization.

R206's 5 day comprehensive assessment Minimum Data Set dated 1/20/18 indicated R206 was cognitively intact.

A review of Facility Progress Notes indicated R206 Facility Progress Noted indicated R206 was admitted to a hospital on three separate occasions: 11/23/17 to 11/26/17, 1/8/18 to 1/13/18, and 1/24/18 to 1/30/18. The medical record lacked evidence a bed hod notice had been provided to R206 for any of the hospitalizations.

During an interview on 2/15/18, at 10:03 a.m. the administrator and the director of nursing (DON) said bed hold documents were completed by the social worker or a member of the admission department. The administrator and DON confirmed that no bed hold documents had been given to R206, and no bed hold documents were present in R206's medical record.

The facility Bed Hold Policy dated 2016 stated "At the time a resident is to leave the Community for a temporary stay in a hospital or a therapeutic leave (or within 24 hours in the case of an emergency transfer), the Resident/Resident's Representative will be given a written copy of the bed hold policy and may elect to hold open the Resident's room and bed until the Resident returns."

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F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct quarterly care conferences for 4 of 4 residents (R66, R198, R146, R153) reviewed for comprehensive care plan conferences. Findings include:	F 657	R66, R198, R146, and R153 have had comprehensive care plan conferences completed. Residents and families, if applicable, have been invited to the conference. Residents will have comprehensive care plan conferences completed quarterly.	3/27/18

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F 657	Continued From page 38 R66's quarterly Minimum Data Set (MDS) dated 12/2/17, indicated independence with decision making, was able to make self understood and could understand others. R66's care area assessment dated 3/13/17, for cognitive loss/dementia indicated R66 was able to communicate wants and needs to others. R66's care plan dated 12/19/17, indicated a potential problem related to psychosocial well-being and directed staff to provide opportunities for R66 to participate in care. Review of progress notes from 7/31/18 to current survey, identified a social worker quarterly review on 2/16/17 and 11/28/17. There was no evidence of care conferences conducted or attempts to contact R66 for a care conference. During an interview on 2/13/18, 9:38 a.m., R66 stated had not had a care conference since last February, was not aware why care conference had not occurred, and had not not been invited to a care conference. R198's quarterly MDS dated 1/14/18, indicated an ability to make self understood and understand others. The MDS indicated R198 had intact cognition. A care area assessment (CAA) for cognitive loss/dementia indicated R198 was able to effectively make her wants and needs know to others. Review of R198's progress notes from 8/23/17 to 2/20/18, lacked evidence quarterly care conferences had been held. During an interview on 2/12/18, at 4:54 p.m. R198 stated "I haven't gone to a care conference, I had	F 657	Conference will include members of the interdisciplinary team. Resident and resident representatives will also be invited to attend. Education has been provided to social service and nurse leadership regarding the scheduling and completion of comprehensive care plan conferences. Director of social service and/or designee will audit 5 residents per week for 4 weeks, then monthly for 2 months for completion of conferences per facility policy. Director of social service will monitor compliance.	

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one about a year ago." R168 further indicated would like to have one.

During an interview on 2/14/18, at 1:21 p.m. Director of Social Services (DSS) stated care conference notes would have been in the resident's progress notes or under care conference note in the electronic medical record. The DSS stated the MDS nurse would have sent a list by the end of the week on who was due for an assessment and a care conference would be set the following week. The DSS stated if the resident was their own responsible party, the resident should have received a slip of paper to be invited to the care conference.

During an interview on 2/15/18, at 8:06 a.m., the DSS stated she unable to find any care conference notes for R66 or R198.

R146's Admission Record indicated admission to the facility occurred on 5/16/17. R146's quarterly Minimum Data Set (MDS) dated 1/9/18, indicated she had intact cognition.

During an interview on 2/12/18, at 6:44 p.m., R146 stated the interdisciplinary team (IDT) held her last care conference without her.

During an interview on 2/14/18, at 9:36 a.m., the director of nursing stated R146 had last attended a care conference meeting on 9/14/17.

During an interview on 2/15/18, at 8:15 a.m., the director of social services said the frequency of the care conference meetings should be quarterly and a care conference involving R146 should have occurred in December of 2017.

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F 657	Continued From page 40 R153's Admission Record indicated admission to the facility occurred on 10/8/16. R153's quarterly MDS dated 1/12/18 indicated intact cognition. During an interview on 2/12/18, at 1:11 p.m., R153 stated she had not met the IDT for a care conference in a while. During an interview on 2/15/18, at 8:25 a.m., the director of social services (DSS) stated R153's last care conference occurred on 4/19/17. The DSS stated care conferences should have occurred in July and October of 2017 and January of 2018. A Facility policy titled Resident/Family Participation- Assessment/Care Plans dated November 2012, indicated "Each resident and his/her family members are encouraged to participate in the development of the resident's comprehensive assessment and person-centered care plan." Policy Interpretation and Implementation directed staff to "1. The resident and /or his/her representative, are invited to attend and participate in the resident's assessment and care planning conference. Notice shall be made by mail, electronic and/or telephone in a language that he or she can understand."	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances	F 676		3/27/18

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F 676	Continued From page 41 of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure positioning and hygiene needs were met for 1 of 1 resident (R82) reviewed for activities of daily living. Findings include:	F 676	R82 was assisted with shaving. R82 will be repositioned and provided incontinence care per the plan of care. Residents will receive care per their individualized plan of care and per standards of practice. Including but not	

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F 676	Continued From page 42 R82's care plan dated 12/20/17, indicated R82 required extensive assistance of 2 staff for transfers and required every two hour repositioning due to skin breakdown and pressure ulcers. The care plan further indicated R82 required assistance with personal hygiene. R82's Care Area Assessments (CAA) dated 7/18/18, indicated R82 required extensive assistance of two staff for transfers and repositioning. On 2/12/18, at 5:04 p.m. R82 was not shaved. R82's face was dirty with brown drool from the corners of his mouth down to his chin. A safety razor and shaving cream were sitting out on shelf beside the television. R82 stated he needed assistance to brush his teeth, get dressed, and shave one or two times a week on shower days. R82 stated that no one helped him to shave. During observations on 2/14/18, from 7:40 a.m. to 10:38 a.m. R82 was sitting in a wheelchair in the hallway near the nurses station with his head down, eyes closed, and a towel under his chin .R82 was not shaved and had brown debris under his fingernails. At 7:48 a.m. a nursing assistant (NA) pushed R82 in a wheelchair to the dining room. At 8:09 a.m. R82 remained at the table in the dining room with head down, eyes closed and food on the table. At 9:00 a.m. R82 remained sitting in wheelchair at the dining room table until 9:57 a. m. when registered nurse (RN)-F brought him to the nurses station for medication. At 10:23 a.m. R82 was still sitting in wheelchair in the hallway across from the nurses station. At 10:25 a.m. RN-F stated that R82 would have been repositioned after breakfast. At 11:00 a.m. R82 remained in hallway near the nurses station. On 2/14/18, 1:00 p.m. R82 was observed in room	F 676	limited to shaving, incontinence care, and repositioning. Licensed staff and NARs have received education regarding the need for staff to assist with activities of daily living as noted in the individualized plan of care. DON/designee will audit 10 residents per week for 1 month and monthly for 2 months. Audit will include monitoring of repositioning and toileting/incontinence care per the plan of care. Audit will also include monitoring of personal hygiene including shaving. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 676	Continued From page 43 329. Staff assisted R82 out of the wheelchair and into a reclining chair. NA-C and another NA transferred R82 with a sit to stand mechanical lift. While standing in the lift, NA-C changed R82's incontinence brief. R82 was noted to have a long red mark on the left inner thigh and an excoriated area on the left buttock, with white cream on it. NA-C provided incontinence cares and applied a white ointment to R82's buttocks. R82 stated it was the first time he had been changed that day. At 10:02 a.m. RN-F stated that R82 is showered 2 times a week. RN-F stated R82 was shaved on shower days and as needed. RN-F added that because of diagnosis of diabetes R82's nails were cleaned and trimmed by the nurse on shower days and as needed. On 2/15/18, at 10:06 a.m. R82 was shaved, however still had dark brown debris under his fingernails. On 2/15/18, at 3:29 p.m. the director of nursing (DON) stated residents should be shaved and have fingernails cleaned according to the plan of care and as needed. The DON further stated she expected staff to reposition residents according to the care plan; if the care plan identified every 2 hours then that was what was expected.	F 676		
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	F 690		3/27/18

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F 690	Continued From page 44 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to 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 assist 1 of 1 resident (R82) to the toilet according to scheduled toileting plan. Findings include: R82's Admission Report dated 2/15/18, indicated diagnoses of Parkinson's disease and	F 690	R82 will be repositioned and provided incontinence care per the plan of care. Residents will receive care per their individualized plan of care and per standards of practice. Including but not limited to shaving, incontinence care, and repositioning.	

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F 690	Continued From page 45 unspecified dementia without behaviors. R82's Care Area Assessments (CAA) dated 7/18/17, for activities of daily living indicated that R82 needed extensive assistance with toileting care. The CAA for urinary incontinence dated 7/18/17, revealed R82 was incontinent of bladder and dependent on staff to manage the incontinence. R82's plan of care dated 12/20/17, indicated that R82 was incontinent of bladder and bowel and needed to be assisted with toileting upon waking, after meals, at bedtime and as needed. During observations on 2/14/18, from 7:40 a.m. through 11:00 a.m., R82 was sitting in a wheelchair in the hallway near the nurses station with his head down, eyes closed and a towel under his chin. At 7:48 a.m. a nursing assistant (NA) wheeled R82 to the dining room. From 8:09 a.m. to 9:30 a.m., R82 remained at the table in the dining room with head down and eyes closed and towel under his chin. The food had been cleared from the table. A housekeeper moved R82 away from the table and vacuumed under the table. At 9:57 a.m. R82 was taken out of dining room to the nursing station by registered nurse (RN)-F for medication. At 10:25 a.m., RN-F was asked when R82 was last repositioned and stated R82 should have been repositioned after breakfast. At 11:00 a.m. R82 remained in the hallway near the nurses station. On 2/14/18, 1:00 p.m. R82 was observed in his room being transferred out of wheelchair into a reclining chair. NA-C and another NA transferred R82 with a sit to stand mechanical lift. While standing in the lift, NA-C changed R82's	F 690	Licensed staff and NARs have received education regarding the need for staff to assist with activities of daily living as noted in the individualized plan of care. DON/designee will audit 10 residents per week for 1 month then monthly for 2 months. Audit will include monitoring of repositioning and toileting/incontinence care per the plan of care. Audit will also include monitoring of personal hygiene including shaving. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 690	Continued From page 46 incontinence brief. The brief was wet with urine. R82's buttocks were pink and a long red mark was noted on the left inner thigh and an excoriated area on the left buttock, with white cream on it. NA-C cleaned R82's groin area with wet wipes. Then NA-C wiped R82's buttocks with a wet wipe and applied a white ointment to the buttocks. R82 stated it was the first time he had been changed that day. At this time RN-F stated R82 had been checked and changed prior to going to lunch. RN-F could not say what time R82 had gotten up and/or was placed into the wheelchair.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 693		3/27/18

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F 693	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastric residual and J-tube and G-tube placement were checked prior to medication administration for 2 of 2 residents (R25, R238) receiving medications through a G-tube and J-tube. In addition, the facility failed to ensure water flushes were completed between medications via J-tube. Findings include: R25's admission Minimum Data Set (MDS) dated 11/14/17 indicated diagnoses that included gastroesophageal reflux disease, aphasia, hemiplegia and respiratory failure. The MDS indicated R25 received tube feedings. On 2/13/18, at 8:50 a.m. R25 was observed lying on her bed. R25 indicated she was experiencing pain. The pain was reported to registered nurse (RN)-J who indicated she would administered the medication. At 8:50 p.m. RN-J retrieved narcotic pain medication from the medication cart. RN-J crushed the medication and poured the powder in a small medication cup. At 8:53 a.m. RN-J entered R25's room asked R25 if she was in pain. R25 stated she was having pain. RN-J added approximately 30 milliliter (ml) of water to the medication powder and mixed it. RN-J then drew 30 ml of water from a graduated cylinder, approached R25 and flushed the G-tube without checking for placement. RN-J then drew the medication with a syringe removed extra air at the tip of the syringe and pushed the medication into the G-tube still without checking G-tube placement. RN-J then obtained another 30 ml of water and flushed the G-tube.	F 693	R 25 and R 238 will have their gastrostomy tubes managed according to facility policy. Placement will be checked prior to administration of medication. Medication will be administered via gravity. Gastrostomy tubes will be managed and maintained per facility policy. Licensed nurses have received education and performed return demonstration/competency regarding the management of gastrostomy tubes. DON/designee will audit 5 resident□s gastrostomy tubes per week for one month and then monthly for 2 months. Audit will include checking placement of tube and procedure for administration of medication. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 693	Continued From page 48 At 9:02 a.m. RN-J acknowledged she had not checked the G-tube placement. RN-J stated R25 did not have an order to check placement before giving medications. RN-J further stated "with good nursing judgement it should be done." R238's quarterly MDS dated 2/1/18, indicated diagnoses that included irritable bowel syndrome, dysphasia, aphasia, and quadriplegia. The MDS further indicated R238 received tube feeding. On 2/13/18, at 9:53 a.m. licensed practical nurse (LPN)-C set up R238's medications to give via jejunostomy tube (J-tube). At 10:33 a.m. LPN-C obtained water in a graduate cylinder then flushed the J- tube with 30 ml of water. LPN-C did not check tube placement and stated resident had a J-tube and she did not have to check placement. From 10:39 to 10:44 a.m. LPN-C administered medications mixed with water seperately into the J-tube. The tube was observed to drain slow. At 10:45 a.m. the J-tube was not draining. LPN-C used a plunger and pushed the medications then poured the medications from barrel of the syringe into a medication cup. LPN-C then flushed the tube and drained the medications back to the barrel. The medication was still draining slowly. At 11:02 a.m. LPN-C again used the plunger to push medications in. The J-tube continued to drain slowly. As LPN-C pushed the medications, R238 was observed moaning and grimacing. At 11:05 a.m. LPN-C used the plunger to push another medication into the tube. R238 was observed grimacing but LPN-C did not ask the resident if she was okay. At 11:25 LPN-C continued to administer mediations. As she poured the medication into the syringe, it was noted the barrel was not draining. LPN-C again used the	F 693		

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F 693	Continued From page 49	F 693		

plunger to push the medication mixture. R238 was again observed grimacing and when surveyor asked R238 if she was ok, R238 made a moaning sound. At this time LPN-C stopped the medication administration and left the room.

On 2/13/18, at 11:49 a.m. LPN-C stated because R238 had a J-tube she did not aspirate the stomach contents and stated the only way to check the tube placement was with an x-ray. LPN-C stated she had pushed the medications and flushes in because she thought she would be able to dislodge the clog with a little push and stated "I don't push medications with a J-Tube." When asked why she had not asked R238 if she was okay when pushing medications she stated she did not think resident was grimacing. LPN-C stated she was trying to learn to read R238's expressions as she had not worked with her for a long time.

On 2/14/18, at 1:24 p.m. RN-I stated he would expect the nurses to check the G-tube placement to make sure it was at the right place. RN-I also stated he would expect medications to be given by gravity and if the nurse was experiencing draining issues to do a light tapping/push. He stated if they were not successful they should stop and call the doctor. RN-I further stated LPN-C was supposed to observe for non verbal signs of discomfort while pushing medications to ensure resident was not experiencing discomfort with the procedure.

On 2/14/18, at 3:31 p.m. the director of nursing (DON) stated she would not expect staff to push medications when meeting resistance. The DON stated the nurses were supposed to administer medications using gravity.

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F 693	Continued From page 50 On 2/15/18, at 12:07 p.m. the DON stated she expected tube placement to be checked prior to administering medications. The facility policy titled, Confirming Placement of Feeding Tubes policy revised October 2010, directed staff for "16. For naso-gastric, esophagostomy, or gastrostomy tubes, check placement and gastric contents. 19. Administer medication by gravity flow or administer gentle boosts with plunger, approximately 1 inch down if the medications will not flow by gravity..."	F 693		
F 697 SS=D	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, 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 observations, interview and document review, the facility failed to ensure 1 of 6 residents (R258) who received as needed narcotic pain medications had non-pharmacological interventions. Findings include: R258's quarterly minimum data set (MDS) dated 2/2/18, indicated he was moderately cognitively impaired and reported frequent pain that limited his day to day activities. R258's care plan did not address non-pharmacological interventions for	F 697	R258 had a new pain assessment completed. Plan of care was updated with non-pharmacological interventions. Medication administration of as needed pain medication has been reviewed by NP. Pain management including non-pharmacological interventions will be included on resident care plans. Pain management will be addressed at clinical startup for those residents triggering for pain or noted with increased use of as	3/27/18

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F 697	Continued From page 51 pain. R258's Physician Order dated 1/11/18, identified an order for Oxycodone 5 mg by mouth every four hours as needed for pain for pain rating 5-7 give 1 tablet and for pain rating 8-10 give 2 tablets. On 2/12/18, at 6:12 p.m. when asked if he had pain, R258 stated he had lower back pain and the pain medication he received did not help relieve the pain for as long as it should. R258 stated "the pain affects my sleep big time." R258 stated he had a hard time sleeping and stated the pain affected his day time activities. R258 stated he had been bed bound on Saturday due to his pain and stated nothing had been done. He stated staff had not offered non-pharmacological interventions and stated he reported a pain rating of 8 of 10 and staff only recorded it. On 2/14/18, at 9:35 a.m. R258 stated stated his pain was always there and the pain medication took the edge off. R258 stated because he was on dialysis his medications were a challenge. He stated there was no non-pharmacological interventions offered to him prior to medication. He stated his pain was in his back and at times, in his legs. On 2/15/18, at 1:52 p.m. licensed practical nurse (LPN)-D stated R258 received PRN Oxycodone 5 milligram (mg) every four hours. LPN-D stated when R258 went to dialysis at times would get it before he left. LPN-D further stated stated R258 was alert and was able to verbalize pain and staff assessed his pain every shift. A review of the of the narcotic register indicated R258 had received the PRN Oxycodone 32 times since 2/1/18. When asked if resident had been offered any non-pharmacological interventions prior to the	F 697	needed medication. Licensed staff were educated on providing non-pharmacological interventions per individualized plan of care. Staff were also educated to monitor as needed pain medication use and need for further interventions. DON/designee will complete a pain management audit on 10 residents weekly for a month, then monthly for 2 months. Audit to include interview with resident on effectiveness of plan. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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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 697	Continued From page 52 medication, LPN-D verified there was none documented in the medical record. During review of the February Medication Administration Record (MAR) it was revealed R258 had received the Oxycodone PRN 37 times from 2/1/18, through 2/14/18. The medical record lacked documentation for non-pharmalogical interventions offered and there was no documentation, the doctor or nurse practitioner had been notified for the frequent administration of the Oxycodone PRN. On 2/15/18, at 2:02 p.m. registered nurse (RN)- I verified R258 had received the Oxycodone as needed 37 times per the Narcotic book. RN- I further verified R258 did not have the pain care plan and verified R258's doctor/nurse practitioner had not been updated about the increased use of the pain medication. RN-I verified staff were not documenting non-pharmacological interventions prior to the administration of pain medications.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		3/27/18

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F 725	Continued From page 53 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate staffing was provided to meet the needs of 14 of 289 residents (R141, R236, R89, R206, R38, R210, R187, R82, R198, R216, R49, R263, R253, R249) who resided in the facility. Findings include: Refer to F565. The the facility failed to effectively respond to resident council grievances related to staffing patterns and call light response times, for 9 of 9 resident council members (R94, R44, R169, R216, R60, R30, R99, R116, R124) present during the resident council meeting with survey team. R141's quarterly minimum data set (MDS) dated 1/8/18, indicated R141 had moderate cognitive impairment. During an interview on 2/12/18, at 1:19 p.m. R141 stated that sometimes R141 has had to wait an	F 725	The facility will have sufficient nursing staff 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. Call light system is equipped with pagers attached to alert staff when resident activates call light. Pagers are in place with nurses and nursing leadership. Alternative staffing arrangement are available when staff call in and a replacement is not available. Staffing coordinator and clinical leadership communicate in regard to potential staffing challenges and needs on units based on acuity and resident needs. Schedules are in place for assistance and supervision by staff during meal times. Compliance of systems in place will be	

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F 725	Continued From page 54 hour to an hour and a half for staff. R236's admission MDS dated 1/29/18, indicated R236 was cognitively intact. During interview on 2/13/18, at 11:21 a.m. R236 stated at times it takes a couple of hours to get help when R236 puts light on to use bathroom. R89's quarterly MDS dated 12/7/17, indicated R89 was cognitively intact. During interview on 02/12/18, at 6:48 p.m. R89 stated he waited all morning for pain pills. R89 further stated staff were not quick with answering the lights and that they did not have enough help. R89 stated the wait time could be over an hour with the nursing assistants they had on the floor. R206's significant change MDS dated 11/15/17, indicated R206 had moderate cognitive impairment. During interview on 2/12/18, at 6:59 p.m. R206 stated that wait time for anything was long, about 45 minutes and that weekends were worse. R206 stated this happened a couple times a week. R38's quarterly MDS dated 11/22/17, indicated R38 was cognitively intact. During interview on 2/13/18, at 10:01 a.m R38 stated that when done eating R38 had to go to the bathroom, and everyday R38's sister came to put her on the toilet and that staff are never around to get her to the bathroom in time. R210's quarterly MDS dated 1/23/18, indicated R210 was cognitively intact. During interview on 2/12/18, at 4:27 p.m. R210 stated the call light had been on for over an hour.	F 725	audited through verbal interviews with residents, review of grievances by administrator or designee, and review of minutes monthly from resident and family council meetings. Results and trends of concerns and grievances will be reviewed monthly at QAPI. Administrator to monitor compliance.	

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R187's significant change MDS dated 1/12/18, indicated R187 was cognitively intact.
During interview on 2/13/18, at 10:42 a.m. R187 stated the aides did double duty in the dining room, R187 stated that because of this, everyone had to be very patient during meals.

R82's quarterly MDS dated 12/15/17, indicated R82 had moderate cognitive impairment.
During interview on 2/12/18, at 4:55 p.m. R82 stated that staff did not answer call lights and that it depended on who the staff were. R82 stated that the staff did not understand that when nature called you have to go.

R198's quarterly MDS dated 1/14/18, indicated R198 was cognitively intact.
During interview on 2/12/18, at 4:52 p.m. R198 stated that it took a long time to answer call lights. R198 stated it was an hour before the light was answered. R198 stated the long call light wait generally occurred in the morning.

R216's annual MDS dated 1/26/18, indicated R216 was cognitively intact.
During interview on 2/12/18, at 6:11 p.m. R216 stated that sometimes the staff did not give R216 enough time to take care of her teeth. R216 stated there was not enough help and that it took a long time for the call light to be answered. R216 reported waiting as long as an hour to have the call light answered.

R263's annual MDS dated 1/24/18, indicated R263 was cognitively intact.
During interview on 2/12/18, at 2:48 p.m. R263 indicated a wait time of about one and a half hours for call lights to be answered, both in the evening and morning hours.

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R49's admission MDS dated 11/2/17, indicated R49 was cognitively intact.
During interview on 2/13/18, at 9:23 a.m R49 stated they had not been keeping up with Parkinson's medication administration times as R49 reports that the staff think they still have plus one hour either side of the scheduled time. R49 stated she needed to have it on schedule and that they were always half an hour to 2 hours late. R49 stated it was better when there was a nurse on duty.

On 2/15/18, at 11:17 a.m. the staffing coordinator verified the following:
- 1/13/18, the facility was short two nursing assistant shifts that the facility did not fill.
- 1/14/18, the facility was short three nursing assistant shifts that the facility did not fill.
- 1/27/18, the facility was short a charge nurse shift that the facility did not fill.
- 2/8/18, the facility was short a charge nurse shift that the facility did not fill.
- 2/11/18, the facility was short a nursing assistant and a charge nurse shift that the facility did not fill.

During interview with administrator on 2/15/18, at 11:41 a.m. the administrator stated since the start of her employment in September changes to the staffing patterns had taken place with an increase to nursing assistants to the schedule on the night shift that took place in January. The administrator stated the changes to the scheduled staff was done as a result of hours per patient a day (PPD) and that could be higher, acuity of residents, resident counsel concerns and the delay in call light response. The administrator stated that as a result of that they reduced the amount of nurses

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and increased the nursing assistant on certain units. The administrator stated that not all nurses had pagers to the soundless call light system and that this week they should all have them.

Resident and family interviews

R253's quarterly MDS dated 2/1/18, indicated intact cognition and a need for extensive assistance of one to two staff with toilet use, bed mobility, transfers, dressing and personal hygiene

On 2/13/18, at 4:50 p.m. when asked if she received the care and assistance she needed without having to wait for a long time R253 stated staffing was a problem at the facility and the staff were not being paid well and were overworked. R253 stated the call lights take forever to be answered and there was only one nursing assistant for all the residents in the unit. R253 stated she she was discharging from the facility however, wanted the issue about staffing and staff answering the call lights to be fixed for other residents.

R249's 14 day MDS dated 2/1/18, indicated R253 had intact cognition. In addition, the MDS indicated R249 required extensive assistance of one to two staff with toilet use, bed mobility, transfers, dressing and personal hygiene

On 2/12/18, at 5:49 p.m. R249 stated the facility was short staff. R249 stated the call lights took a long time to be answered and the other night he had woken up at 1:32 a.m. put the call light on for one hour before someone came and had an accident on "the diaper" and this has been since I came about a week ago and this has affected me and I talked to the social worker. The nursing

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home was good and has changed and the problem is staffing and for me to lay in bed with my dump in my bed that is bad and I feel they don't have enough staff to meet the patient needs. I had my wife come here and I had an accident I don't want to sit on my dump. I cannot recover when am sitting in my dump. People sometimes sit here at night and sometimes yelling and calling for assistance. The facility is short handed."

On 2/13/18, at 12:02 p.m. anonymous family member approached and stated the only concern was staffing and that it was a was a huge problem at the facility. When arriving to visit resident, sometimes found resident siting up, soaked in urine and bowel movement. Family member further stated at times when visiting resident she would put the call light on and staff would not answer the call light for up to an hour later and staff would come to the room and say, "your call light is on. You think it's been on for one and a half hours and you are asking me. They are rude in the way they ask." Family member stated she was surprised resident's wound was even getting better as most of the time when coming to visit resident was sitting in urine and bowel movement.

Staff interview
On 2/13/18, at 10:20 a.m. when asked about staffing nursing assistant (NA)-J reported staffing was bad and you can work and not even get done. NA-J explained that sometimes the residents cares are very heavy and we don't have enough staff to meet the cares and needs. NA-J explained that management has been told and nothing is being done. "Sometimes people call in

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F 725	Continued From page 59 and they don't even replace them and we are told just work with what you have and this is not good for the residents because we don't get to toilet and reposition residents timely. I feel bad sometimes but I have to just do my best with what I have been given to work with." On 2/15/18, at 11:28 a.m. NA-K stated when asked about staffing, "I do not work on this side. I can not get to all the lights not even during meals. We answer the lights as soon as possible and tell them we will get back. We try hard to get back as soon as possible."	F 725		
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	F 726		3/27/18

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F 726	Continued From page 60 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' 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 licensed nursing staff demonstrated competency skills related to medication administration through a tube feeding for 2 of 2 residents (R25, R238) and checking placement of a feeding tube for 2 of 2 residents (R25, R238) reviewed for tube feeding. Findings include: R25's admission Minimum Data Set (MDS) dated 11/14/17 indicated diagnoses that included gastroesophageal reflux disease, aphasia, hemiplegia and respiratory failure. The MDS indicated R25 received tube feeding. On 2/13/18, at 8:50 a.m. R25 was observed lying on her bed. R25 indicated she was experiencing pain. The pain was reported to registered nurse (RN)-J who indicated she would administered the medication. At 8:50 p.m. RN-J retrieved narcotic pain medication from the medication cart. RN-J crushed the medication and poured the powder in a small medication cup. At 8:53 a.m. RN-J entered R25's room asked R25 if she was in pain. R25 stated she was having pain. RN-J added approximately 30 milliliter (ml) of water to the medication powder and mixed it. RN-J then drew 30 ml of water from a graduated cylinder,	F 726	R 25 and R 238 will have their gastrostomy tubes managed according to facility policy. Placement will be checked prior to administration of medication. Medication will be administered via gravity. Gastrostomy tubes will be managed and maintained per facility policy. Licensed nurses have received education and performed return demonstration/competency regarding the management of gastrostomy tubes. DON/designee will audit 5 resident□s gastrostomy tubes per week for one month and then monthly for 2 months. Audit will include checking placement of tube and procedure for administration of medication. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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approached R25 and flushed the G-tube without checking for placement. RN-J then drew the medication with a syringe removed extra air at the tip of the syringe and pushed the medication into the G-tube still without checking G-tube placement. RN-J then obtained another 30 ml of water and flushed the G-tube.

At 9:02 a.m. RN-J acknowledged she had not checked the G-tube placement. RN-J stated R25 did not have an order to check placement before giving medications. RN-J further stated "with good nursing judgement it should be done."

R238's quarterly MDS dated 2/1/18, indicated diagnoses that included irritable bowel syndrome, dysphasia, aphasia, and quadriplegia. The MDS further indicated R238 received tube feeding.

On 2/13/18, at 9:53 a.m. licensed practical nurse (LPN)-C set up R238's medications to give via jejunostomy tube (J-tube). At 10:33 a.m. LPN-C obtained water in a graduate cylinder then flushed the J- tube with 30 ml of water. LPN-C did not check tube placement and stated resident had a J-tube and she did not have to check placement. From 10:39 to 10:44 a.m. LPN-C administered medications mixed with water seperately into the J-tube. The tube was observed to drain slow. At 10:45 a.m. the J-tube was not draining. LPN-C used a plunger and pushed the medications then poured the medications from barrel of the syringe into a medication cup. LPN-C then flushed the tube and drained the medications back to the barrel. The medication was still draining slowly. At 11:02 a.m. LPN-C again used the plunger to push medications in. The J-tube continued to drain slowly. As LPN-C pushed the medications, R238 was observed moaning and grimacing. At 11:05

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a.m. LPN-C used the plunger to push another medication into the tube. R238 was observed grimacing but LPN-C did not ask the resident if she was okay. At 11:25 LPN-C continued to administer mediations. As she poured the mediation into the syringe, it was noted the barrel was not draining. LPN-C again used the plunger to push the medication mixture. R238 was again observed grimacing. At this time surveyor asked R238 if she was okay, R238 made a moaning sound. At this time LPN-C stopped the medication administration and left the room.

On 2/13/18, at 11:49 a.m. LPN-C stated because R238 had a J-tube she did not aspirate the stomach contents and stated the only way to check the tube placement was with an x-ray. LPN-C stated she had pushed the medications and flushes in because she thought she would be able to dislodge the clog with a little push and stated "I don't push medications with a J-Tube." When asked about why she had not asked resident if she was okay when pushing medications she stated she did not think resident was grimacing. LPN-C sated and she was trying to learn to read R238's expressions as she had not worked with her for a long time.

On 2/14/18, at 1:24 p.m. RN-I stated he would expect the nurses to check the G-tube placement to make sure it was at the right place. RN-I also stated he would expect medications to be given by gravity and if the nurse was experiencing draining issues to do a light tapping/push. He stated if they were not successful they should stop and call the doctor. RN-I further stated LPN-C was supposed to observe for non verbal signs of discomfort while pushing medications to ensure resident was not experiencing discomfort

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F 726	Continued From page 63 with the procedure. On 2/14/18, at 3:31 p.m. the director of nursing (DON) stated she would not expect staff to push medications when meeting resistance. The DON stated the nurses were supposed to administer medications using gravity. On 2/15/18, at 12:07 p.m. the DON stated she expected tube placement to be checked prior to administering medications. The facility policy titled, Confirming Placement of Feeding Tubes policy revised October 2010, directed staff for "16. For nasogastric, esophagostomy, or gastrostomy tubes, check placement and gastric contents. 19. Administer medication by gravity flow or administer gentle boosts with plunger, approximately 1 inch down if the medications will not flow by gravity..."	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		3/27/18

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F 755	Continued From page 64 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure verification of expiration dates of insulin pens resulting in the administration of expired insulin for 2 of 2 residents (R136, R113). Findings include: During observation of medication cart on 2/15/18, at 7:19 a.m. R136's Lantus SoloSTAR insulin (a long acting injectable medication to treat diabetes) pen was in the top drawer of the cart. The date written on the insulin pen as the date the pen was opened was 1/4/18. No expiration date was noted on the Lantus pen. Registered nurse (RN)-M verified the date opened on the Lantus pen and stated the lantus would have expired in 28 days on 2/1/18. RN-M stated R136 had received a dose every morning from 2/1/18, through 2/15/18. R136 received 14 doses of	F 755	Expired medications for R136 and R113 were destroyed and new supply of medication was ordered. Medications in carts were reviewed to ensure medications were not expired and dated per policy. Licensed nurses have been educated regarding facility policy for storage of medication which indicates that the facility will not use outdated or expired drugs. Re-education included the requirements for labeling and dating medications. DON/Designee will audit up to 5 medication carts weekly for 1 months and monthly for 2 months to ensure proper labeling and dating of medications. Results of the audit will be forwarded to	

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F 755	Continued From page 65 Lantus from an expired insulin pen. An Order Summary Report printed 2/15/18, indicated R136 was to receive Lantus 5 units every morning for diabetes. During observation of medication cart on 2/15/18, at 7:53 a.m. R113's Novolog (a short acting medication for the treatment of diabetes.) Flex pen was in the top drawer of the cart. The date was written on the flexpen as the date the insulin pen was opened was 1/2/18 and was marked as expiring on 1/30/18. RN-N verified the date on the insulin pen and stated R113 received insulin any time R113's blood sugar check was greater than 200. An Order Summary Report printed 2/15/18, indicated indicated R113 was to receive Novolog 6 units twice a day if blood sugar was greater than 200. R113's February 2018, Medication Administration Record (MAR) indicated R113 had received six doses of Novolog from 2/1/18-2/15/18. During interview on 2/15/18, at 12:22 p.m. the consultant pharmacist stated Novolog and Lantus expire 28 days after they were opened. The consultant pharmacist stated expired medications should not be given to residents. During an interview on 2/15/18, at 2:09 p.m. the director of nurses (DON) stated nurses were to check for expiration dates and if expired, throw the insulin pen away and get a new pen. The DON stated the nurses should not be giving residents expired medication.	F 755	the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 755	Continued From page 66 A facility policy titled Storage of Medications dated April 2007, indicated the facility shall not use outdated or deteriorated drugs or biologicals. Such medications should be returned to the pharmacy for destruction.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to store refrigerated medications between 36-46 degrees Fahrenheit	F 761	Medications that were noted to be stored outside of recommended temperature parameters were destroyed and a new	3/27/18

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F 761	Continued From page 67 (F) in 5 of 10 medication rooms. This had the potential to affect all residents who received refrigerated medications from those medication rooms. In addition the facility refrigerated a stock medication that was to be stored at room temperature. Findings include: On 2/15/18, at 7:35 a.m. registered nurse (RN)-O verified the 800 wing medication room refrigerator temperature was 34 degrees F. Stored in the refrigerator were two vials of pneumovax, ten vials of hepatitis B vaccine, one Novolog Flexpen and one pneumococcal 13 vaccination. RN-O stated this wing was not in use and the medications were waiting to be transferred to the appropriate wings. RN-O verified there was no Refrigerator Temp log on the refrigerator. At 8:00 a.m. RN-N verified the Bridgeway south medication room refrigerator temperature was 32 degrees F. Stored in the refrigerator were eight humalog Kwick pens, one Novolog Flexpen, and three Lantus SoloSTAR pens, seven bottles of Latanoprost 0005% eye drops, one bottle of liquid gabapentin, 20 vials of hepatitis B vaccine and one vial of Tubersol. RN-N stated the temperature of the refrigerator should be at least 36 degrees. At 8:23 a.m. RN-J verified the 500 wing medication room refrigerator temperature was 25 degrees. Stored in the refrigerator were three bottles of acidophilus, one bottle of liquid gabapentin, one bottle of liquid vancomycin, three vials of Tubersol, and one vial of injectable Benadryl. RN-J stated the medications were moved to the 500 wing on Tuesday. RN-J verified	F 761	supply of medication was ordered. Refrigerator temperatures are currently within set parameters, logs in place. Licensed staff have been educated on facility policy regarding storage of medication. Education included actions to take if temperature is outside recommendations. DON/designee will audit refrigerators with medication storage for appropriate temperature every week for a month then monthly for 2 months. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 761	Continued From page 68 the Refrigerator Temp Log was blank. At 8:35 a.m. licensed practical nurse (LPN)-F verified the 600 wing medication room refrigerator temperature was 29 degrees. LPN-F stated the inside of the refrigerator felt colder than normal. LPN-F stated the night shift had recorded the temperature as 38 degrees that morning. Stored in the refrigerator were one bottle of liquid vancomycin, two humalog Kwick pens and one Novolog FlexPen At 9:06 a.m. LPN-G verified the 2SW wing medication room refrigerator temperature was 19 degrees. The thermometer was on the shelf and the medications were stored in door. The medications were not frozen but cold to touch. LPN-G stated the fridge felt cold and would need to notify maintence. LPN-G stated did not know how to adjust the temperature in the refrigerator. LPN-G stated the temperature should be between 36 and 46 degrees. Stored in the refrigerator were one bottle of liquid omeprazole, one bottle of magic mouth wash, one vial of Aplisol, 7 degludec flexpens , 13 Novolog flex pen, 8 tresiba flex pen, 2 lantus SoloStar pens, and 9 humalog pens. Also stored in the refrigerator was a glucagon pen whose label indicated it was to be stored at 68-77 degrees. LPN-G verified the label instructions and stated it should not be stored a refrigerator. At 9:31 a.m. LPN-G and the maintenance director verified the temperature was now up to 28 degrees. The maintenance director lowered the refrigerator dial and stated that would raise the temperature to between 36 and 46 degrees within 24 hours. RN-G reviewed the Refrigerator Temp logs for January and February and verified the lowest temperature was recorded as 14 degrees	F 761		

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F 761	Continued From page 69	F 761		

and the highest temperature recorded was 24 degrees.

During interview on 2/15/18, at 8:09 a.m. RN-D stated refrigerator temperatures were to be maintained between 36 to 45 degrees to make sure the medications stayed viable. RN-D stated if a medication froze the medication might not be as effective as it should be.

During interview on 2/15/18 at 12:22 p.m. the consultant pharmacist stated the medication refrigerators should be kept between 36 and 46 degrees and stated if there were deviations, that would be addressed. The consultant pharmacist stated some medications do not freeze so staff would need to look at specific manufacture. The consultant pharmacist stated she glanced at the logs on visits but did not look at actual temperature. The consultant pharmacist stated medications listed in 2SW refrigerator should not be stored at 19 degrees.

During interview on 2/15/18 at 2:09 p.m. the director of nursing (DON) stated it was her expectation that the refrigerator temperatures would be within range.

Findings include:

On 2/14/18, at 3:00 p.m. the third floor north medication refrigerator was 28-30 degrees Fahrenheit (F). Licensed practical nurse (LPN)-A verified the temperature and the following medications stored in the refrigerator:

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F 761	Continued From page 70	F 761		

10 Humalog insulin pens, 11 Novolog Flex insulin pens, 12 Lantus Solostar insulin pens, three bottles of Latanoprost eye drops, a 30 milliliter (ml) bottle of lorazepam (anti-anxiety), two 5 ml bottles of Timolol maleate eye drops. one vial of injectable Cyanocobalamin (Vitamin B-12), one vial of injectable engerix-B (for hepatitis B), and one 2.5 ml bottle of Latanoprost eye drops, one 0.5 ml vial of influenza vaccine and one opened 1 ml vial of tuberculin solution

On 2/14/18 at 3:26 p.m. RN-B stated the fridge should be kept at 40 degrees. RN-B verified the refrigerator temperature log indicated the temperature had been below 36 degrees most days since 1/9/18. RN-B stated the nurses should call the nurse manager or the supervisor when the temperature is out of the acceptable range of 36 degrees F to 46 degrees F, as indicated on the temperature log. RN-B reset the temperature on the refrigerator and stated he would call the pharmacist. All of the medications were in liquid form at that time.

On 2/24/18, at 3:35 p.m. RN-B stated called the pharmacy and was told that unless the medication was visibly frozen, it should be OK. RN-B stated the pharmacist informed him that it would not freeze above 25 degrees F. RN-B stated he had asked about insulin and the Ativan, but had not asked about the other medications. He stated he would do so. RN-B verified the medications should be stored between 36 degrees F and 46 degrees F.

On 2/15/18, at 9:18 a.m. the third floor North medication refrigerator was 36 degrees. Medications remained in the refrigerator.

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F 761	Continued From page 71 On 2/15/18, at 9:22 a.m. RN-C asked the consultant pharmacist for guidance on the medication storage in the refrigerator. Consultant Pharmacist (CP) stated she was checking with the pharmacy. RN-C stated they would get new eye drops to replace those per the pharmacy recommendations. On 2/15/18, at 11:07 a.m. the director of nursing (DON) stated the refrigerator temperatures were checked every night shift and her expectation was to reset the refrigerator temperature if it were too cold or too warm, recheck the temperature and call maintenance or put in a work order for them to check the refrigerator. The DON stated the pharmacy would be called if the temperature were out of range and ask them if the medications could still be used. The DON stated the pharmacy was checking on the medications in the refrigerators that were too cold, and if they needed to be replaced, the facility would replace them. The DON stated the staff needed to be educated. A facility policy policy titled Storage of Medications, dated April 2007, indicated medications requiring refrigeration must be stored in a prestidigitator in the medication rooms. The policy did not address maintain refrigerator temperatures.	F 761		
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	F 880		3/27/18

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F 880	Continued From page 72 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 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.	F 880		

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F 880	Continued From page 73 (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 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 complete adequate hand hygiene with personal cares for 1 of 3 residents (R238) reviewed for pressure ulcers. Findings include: R238's quarterly minimum data set dated 2/1/18, indicated she required assistance from two staff for transfers, toileting and personal hygiene. During observation on 2/15/18, at 7:54 a.m., nursing assistant (NA)-F and NA-G entered R238's room. Both NA's went to R238's beside wearing gloves. NA-F turned R238 to her left side. NA-G removed a bedpan from underneath R238, set it to the side and used toilet paper to	F 880	Hand hygiene is to be performed using proper technique and at appropriate times. Components of our infection control program are being followed. Staff have been re-educated regarding the facility hand washing policy. IC Nurse/Designee will audit up to 5 glove changes per week to ensure ongoing compliance. Audits will be completed weekly for 1 month and monthly thereafter for 2 months. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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F 880	Continued From page 74 wipe stool off R238's bottom. NA-G then removed the plastic lining from the bedpan, rolled the bag, removed gloves as she entered the bathroom and tossed the bag and gloves in the garbage. Without washing her hands, NA-G left the bathroom, touching the door knob. NA-G then opened the main door to R238's room and left without washing hands. At 7:55 a.m. NA-G was interviewed regarding handwashing. NA-G turned around went into the bathroom washed her hands and came out. When NA-G was asked what the facility policy was for hand washing and gloving she stated "I am supposed to wash them. I am so behind and this happens all the time and I always have to help everyone." During an interview on 2/15/18, at 8:02 a.m. registered nurse (RN)-A stated he expected staff to wash hands after providing peri-care and removing gloves. At 8:04 a.m. NA-F verified NA-G had left the room without washing her hands. A facility policy titled Hand Washing/Hand Hygiene, dated April 201, indicated the facility considers hand hygiene the primary means to prevent the spread of infections. The policy directed staff to wash hands before and after direct patient contact and before and after providing resident personal care.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		3/27/18

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F 883	Continued From page 75 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 76 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess the need for or provide pneumococcal vaccines for 1 of 5 residents (R137). Findings include: The Center for Disease Control and Prevention identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R137's Admission Record dated 2/15/18 indicated she admitted to the facility on 5/24/17. Review of a Minnesota Immunization Information Connection form undated, indicated R137 should have received the PCV- 13 vaccination on or after 8/23/13. A facility Immunization record dated 2/20/18, lacked evidence R137 had received the PCV-13 vaccination.. On 2/15/18, 1:22 p.m. registered nurse (RN)-L	F 883	R137 will receive PCV-13 vaccination per CDC recommendations and facility policy. Residents will receive their immunizations will be administered per current guidelines. Nurse managers and clinical coordinators will be educated on CDC recommendations for administration of PPSV23 and PCV13 immunizations. DON/designee will complete audits of 3 residents on each unit weekly for a month then monthly for 2 months. Results of the audit will be forwarded to the QAPI committee monthly for continued quality improvement for 3 months. DON to monitor compliance.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 77 stated the nurse managers were responsible for checking on immunization records and following up to make sure immunizations were administered to the residents. RN-L did not know the reason the immunization had not been completed. RN-L stated there was an admission checklist for the nurse managers to follow and checking the immunization records were one of the tasks on that checklist. A facility policy related to administration of the PCV-13 vaccination was requested but not received.	F 883		

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/15/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 15, 2018. At the time of this survey, North Ridge Health and Rehab 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, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2018

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email 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.

North Ridge Health & Rehab is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. Because the original building and the 4 additions are of the same complying construction type, the facility was surveyed as 1 building. The facility is fully protected throughout by an automatic fire

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K 000	Continued From page 2 sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for fire department notification. The facility has a capacity of 320 beds and had a census of 275 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly separate multiple occupancies with a minimum of 2-hour fire rated construction within accordance with NFPA 101 (2012) The Life Safety Code sections 19.1.3.5 and 8.2.1.3. This deficient practice could effect all	K 133	1. On 2/6/18, the facility submitted a requisition request to our company, for a set of two new doors, displaying the fire rating, to replace the existing doors separating the West Building and the Assisted Living Building. The order was	3/27/18

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K 133	Continued From page 3 275 residents. Findings include: On a facility tour between the hours of 09:30 AM to 3:30 PM on February 15, 2018, it was revealed that one of the double fire doors separating the West Building and the Assisted Living Building, did not have a fire rating tag. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 133	placed on March 7, 2018. 2. The estimated completion date of removal of existing and installation of the new set of doors is May 7, 2018. 3. Director of Maintenance is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	
K 226 SS=F	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a 2-hour fire barrier separating spaces in a horizontal exit in accordance with NFPA 101 (2012) The Life Safety Code, Sections 7.2.4, and 19.2.2.5.1 through 19.2.2.5.4. This deficient practice could effect all 275 residents. Findings include: On a facility tour between the hours of 09:30 AM	K 226	1. On 2/6/18, the facility submitted a requisition request to our company, for a set of two new doors to replace the existing fire door assembly, separating the West Building and East Building. The order was placed on March 7, 2018. 2. The estimated completion date of removal of existing and installation of the new set of doors is May 7, 2018. 3. Director of Maintenance is responsible for the correction and	3/27/18

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K 226	Continued From page 4 and 3:30 PM on February 15, 2018, it was revealed that the double fire doors that separate the East Building and the West Building, were not properly installed fire door assembly. One door was rated at 90 minutes and the other door at 20 minutes. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 226	monitoring to prevent a reoccurrence of the deficiency.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide illumination of the means of egress to include the exit discharge within accordance of NFPA 101 (2012) the Life Safety Code, sections 7.8 and 19.2.8. This deficient practice could effect all 275 residents. Findings include: On a facility tour during the hours of 09:30 AM and 03:30 PM on February 15, 2018, it was revealed that one of the East Building exit doors did not have a light bulb in the exterior light fixture that illuminated the path of egress.	K 281	1. On 2/15/18, the facility installed a new light fixture and light bulb for the East building exit door exterior light fixture for illumination of the path of egress. 2. It was completed on 2/15/18. 3. Director of Maintenance is responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	3/27/18

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K 281	Continued From page 5 This deficient practice was verified by the Director of Maintenance at the time of Discovery.	K 281		