DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: 0T1M Facility ID: 00678

		TO BE COMIT		112 0 1111	Z SOTT ZT TOZITOT		raemey 15: 00070	
1. MEDICARE/MEDICAID PROVID (L1) 245563	DER NO.	3. NAME AND AL (L3) GREEN PIN			OME	4. TYPE OF ACTIO	ON: 7 (L8) 2. Recertification	
2.STATE VENDOR OR MEDICAID	NO.	(L4) 427 MAIN S	TREET NORT	THEAST		3. Termination	4. CHOW	
(L2) 475240600		(L5) MENAHGA	, MN		(L6) 56464	5. Validation 7. On-Site Visit	 Complaint Other 	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After		
6. DATE OF SURVEY 01/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	NG DATE: (L35)	
11LTC PERIOD OF CERTIFICATIO From (a):	N	10.THE FACILITY X A. In Complia		AS:	And/Or Approved Waivers Of	f The Following Pequirem	onto:	
From (a): To (b):		Program Re	equirements e Based On:		2. Technical Personne 3. 24 Hour RN	٠,	ervices Limit	
12. Total Facility Beds	65 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural S	NF) 8. Patient Roo	m Size	
13.Total Certified Beds	65 (L17)	B. Not in Compli	ance with Program	n	5. Life Safety Code	9. Beds/Room		
		Requirements	and/or Applied W	Vaivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF 65	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	AARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:	
Theresa Gullingsrud, F	IFE NEII		2/17/2017	(L19)	Mark Meath	, Enforcement Speci	04/06/2017 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE	STATE AGENCY		
19. DETERMINATION OF ELIGIBI			IPLIANCE WITH HTS ACT:	I CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
X 1. Facility is Eligible to2. Facility is not Eligible	-				3. Both of the Abov	/e :		
2. Facility is not Englor	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	1:	(L30)	
OF PARTICIPATION 06/01/1991	BEGINNING	G DATE	ENDING DAT	TΕ	VOLUNTARY 01-Merger, Closure	05-Fail to	NTARY Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Piovid	er Status Change	
(L27)	B Passind St	uspension Date:	(L44)			00-Active		
	B. Resellid St	uspension Date.	(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	01/30/2017		(L33)	DETERMINATION APP	PROVAI		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245563

February 17, 2017

Ms. Laura Ahlf, Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, Minnesota 56464

Dear Ms. Ahlf:

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

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

Effective January 4, 2017 the above facility is certified:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 17, 2017

Ms. Laura Ahlf, Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, Minnesota 56464

RE: Project Number S55663027

Dear Ms. Ahlf:

On December 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On January 25, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 4, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 4, 2017 and therefore remedies outlined in our letter to you dated December 14, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT
	B. Wing		Y2	1/25/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEN PINE ACRES NURSIN	G HOME	427 MAIN STREET NORTHEAST			
		MENAHGA, MN 56464			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
ID Prefix Reg. #	F0176 483.10(n)	Correction	ID Prefix F0247 483.15 Reg. #		ID Prefix Reg. #	F0279 483.20(d), 483.20(k	Correction Completed
LSC		01/04/2017	LSC	01/04/2017	LSC		01/04/2017
ID Prefix Reg. #	F0282 483.20(k)(3)(ii)	Correction Completed	ID Prefix F0309 483.25 Reg. #		ID Prefix Reg. #	F0312 483.25(a)(3)	Correction Completed
LSC		01/04/2017	LSC	01/04/2017	LSC		01/04/2017
ID Prefix Reg. #	F0441 483.65	Correction	ID Prefix	Correction	ID Prefix Reg. #	_	Correction
LSC		01/04/2017	LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. # LSC		Completed	Reg. # LSC	Completed	Reg. # LSC		Completed
ID Prefix Reg. # LSC		Correction Completed	ID PrefixReg. #	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/mm	DATE 02/17/2017	SIGNATURE OF SURVEYOR 365	536		ATE 01/25/2017
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE		D	ATE
FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016			R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567)		IE EAGULIEVO	□YES □ NO	

POST-CERTIFICATION REVISIT REPORT

			_				
	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT	7			
	B. Wing	Va	, 1/4/2017	Y3			
		12	<u>: </u>	10			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREEN PINE ACRES NURSIN	IG HOME	427 MAIN STREET NORTHEAST					
		MENAHGA, MN 56464					
This report is completed by a q	ualified State surveyor for the Medicare, N	edicaid and/or Clinical Laboratory Improvemen	t Amendments				

program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0353	12/23/2016	LSC			LSC		<u> </u>
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC	_		LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEWI STATE A		REVIEWED BY (INITIALS) TA/mm	DATE 02/17/2017	SIGNATURE OF	SURVEYOR 33562			ATE 01/07/2017
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DA	ATE
FOLLOWUP TO SURVEY COMPLETED ON 11/29/2016				R ANY UNCORRECTED DEFICIENCIE			E EA OU ITYO	YES NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 17, 2017

Ms. Laura Ahlf, Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, Minnesota 56464

Re: Reinspection Results - Project Number S5563027

Dear Ms. Ahlf:

On January 25, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		\Box	DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00678 _{Y1}	B. Wing	Y	2	1/25/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEN PINE ACRES NURSIN	G HOME	427 MAIN STREET NORTHEAST			
		MENAHGA, MN 56464			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

-	,											
ITE	М		DATE	ITEM			DATE	ITEM			DATE	
Y4			Y5	Y4			Y5	Y4			Y5	
ID Prefix	20430		Correction	ID Prefix	20560		Correction	ID Prefix	20565		Correction	
Reg. #	MN Rule 4658. Subp. 1	0210	Completed	Reg. #	MN Ru Subp. 2	le 4658.0405 2	Completed	Reg. #	MN Rule 4658.04 Subp. 3	05	Completed	
LSC			01/25/2017	LSC	-		01/04/2017	LSC			01/04/2017	
ID Prefix	20830		Correction	ID Prefix	20920		Correction	ID Prefix	21375		Correction	
Reg. #	MN Rule 4658. Subp. 1	0520	Completed	Reg. #	MN Ru Subp. 6	le 4658.0525 6 B	Completed	Reg. #	MN Rule 4658.08 Subp. 1	800	Completed	
LSC			01/04/2017	LSC			01/04/2017	LSC			01/04/2017	
ID Prefix	21565		Correction	ID Prefix			Correction	ID Prefix			Correction	
Reg. #	MN Rule 4658. Subp. 4	1325	Completed	Reg. #			Completed	Reg. #			Completed	
LSC			01/04/2017	LSC				LSC				
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction	
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed	
LSC				LSC			-	LSC				
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction	
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed	
LSC				LSC			•	LSC				
REVIEWI STATE A		REVIEWI (INITIALS		DATE 02/17/2	017	SIGNATURE OF	SURVEYOR 33562			DATE 01/25	/2017	
REVIEWI CMS RO		REVIEW! (INITIALS		DATE		TITLE				DATE		
FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016					R ANY UNCORRECTED DEFICIENCI				YES	S 🗆 NO		

Page 1 of 1 EVENT ID: 0T1M12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

IITTAL	ID: 0T1M
CENCV	E:1:4 ID: 00/70

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1. MEDICARE/MEDICAID PROVIDE (L1) 245563 2.STATE VENDOR OR MEDICAID N (L2) 475240600		3. NAME AND AI (L3) GREEN PIN (L4) 427 MAIN S (L5) MENAHGA	NE ACRES NU STREET NOR	JRSING H	OME (L6) 56464	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	ON: 2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other r Complaint
6. DATE OF SURVEY 12/0! 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	1/ 2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	NG DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	65 (L18) 65 (L17)	Compliance1. A X B. Not in Con	ance With equirements e Based On: acceptable POC mpliance with Pro	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural St 5. Life Safety Code	6. Scope of Sc. 7. Medical Di 8. Patient Roo 9. Beds/Room	ervices Limit rector m Size
		Requirements	and/or Applied	Waivers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 65	OWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Jana Bromenshenkel, I	HFE NEII	1	2/28/2016	(L19)	Mark Meath,	Enforcement Specia	01/30/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBII 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		MPLIANCE WITH	H CIVIL		nncial Solvency (HCFA-257 ol Interest Disclosure Stmt e:	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: :	(L30)
OF PARTICIPATION 06/01/1991	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure		NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	er Status Change
28. TERMINATION DATE:	29	D. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 14, 2016

Ms. Laura Ahlf, Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, Minnesota 56464

RE: Project Number S5563027

Dear Ms. Ahlf:

On December 1, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

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 January 10, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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. 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 March 1, 2017 (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 June 1, 2017 (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

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/28/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245563	B. WING _		12/	01/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	as your allegation of Department's acceen rolled in ePOC, yat the bottom of the form. Your electror be used as verificated. Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.10(n) RESIDEI DRUGS IF DEEME. An individual resident the interdisciplinary	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with	F 00	All Completion dates 1/4/	2017	12/23/16
	by: Based on observareview, the facility fadministration of moments of the completed for 1 of self administer a new Findings include:	NT is not met as evidenced tion, interview and document ailed to ensure a self-edication assessment was 1 resident (R42) observed to ebulizer treatment.		It is the policy of Green Pine Acrassess residents for appropriate self-administration of medications. Education was provided to the nuinvolved, on 11/30/16. RNs, LPN: TMAs will be educated regarding policy for self-administration of be medications and nebulizers after. Policy regarding self-administration.	ness of s. urse s, and the oth set up.	
		d with chronic obstructive		medications was revised into 2-s		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/23/2016

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:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245563	B. WING _		12/	01/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
CDEEN	PINE ACRES NURSIN	IC HOME		427 MAIN STREET NORTHEAST			
GREEN	TINE ACKES NUKSII	IS HOME		MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 176	Continued From pa	age 1	F 17	76			
	atrial fibrillation.	e (COPD), hypertension and		One which includes all medica another which is specific for n after set up by RN/LPN/TMA. regarding this policy was com	ebulizers Education		
	10/17/16, indicated and required exten mobility, transfers, assistance with wa	nimum Data Set (MDS) dated IR42 was cognitively intact sive assistance with bed dressing and toileting; limited liking in her room and in the independent with eating and		RN unit managers. An updated assessment was now being utilized by RN unit for anyone who is self-adminis nebulizers after set up. This a is to be done prior to initiating self-administration and quarte	managers stering ssessment		
	indicated an order	ary report, printed on 12/1/16, for DuoNeb Solution 0.5-2.5 opium-Albuterol) 1 vial inhale day for COPD.		Assessment done on R42, ph order obtained, consent signe and care plan updated.			
	On 11/30/16, at 8:4 alone in her room s stated she was goi treatment at this tir	I5 a.m. R42 was observed seated in her wheelchair. R42 ng to do her nebulizer me and proceeded to do so. es this treatment on her own.		A list of residents who are able self-administer their nebulizer up are kept in a binder on each medication cart for cart nurse. This is to be updated by RN u as appropriate and cart nurse unit manager if there are addinesidents they feel should be and possibly added to the list.	s after set ch review. nit manager to notify RN tional assessed		
		edical record lacked a self essment (SAM), care plan or ebulizer treatment.		All staff will be educated of re The new policy will be implem the plan of correction will be in	vised policy. ented and ntegrated		
	nurse (LPN)-B stat treatment on her o the medication on documented that a	:15 p.m. licensed practical sed R42 did her nebulizer wn. LPN-B stated staff set up their morning rounds and s administered on R42's stration record (MAR). LPN-B		into the quality assurance pro- evaluated for its effectiveness designee, who will monitor co with the policy by auditing one weeks, monthly x3 months, ar will be brought to QA meeting	by DON or mpliance e weekly x4 nd findings		
	stated R42 was us treatment on her o	ed to doing the nebulizer wn from when she lived at s not like to have help. LPN-B		The facility alleges that it will be substantial compliance with the indicated by January 4, 2017.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245563	B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	of medications and an assessment, orc R42 to do self admitreatment. After sea electronic record, L find a SAM assession On 11/30/16, at 12: (DON) stated if a retheir nebulizer treat assessed by a regis planned. The DON assessed for SAM assessed	onsider this self administration she did not know if there was der or care plan in place for inistration of her nebulizer arching through R42's PN-B confirmed she could not ment for R42. 39 p.m. the director of nursing esident was to self-administer ment, their ability should be stered nurse and care confirmed R42 had not been ability and self administration not identified on R42's care	F 176			
F 247 SS=D	residents had the rimedications if deterinterdisciplinary teare-assessed quarte a statement confirmadminister medicat 483.15(e)(2) RIGHTROOM/ROOMMATA resident has the right the resident's room changed.	of Medications indicated ght to self-administer rmined safe to do so by the m. This was also to be rly, and residents were to signing their wish to self ions. T TO NOTICE BEFORE	F 247			12/23/16
	by:	and document review, the		It is the policy of Green Pine Acres	to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		245563	B. WING		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD		01/2010
				427 MAIN STREET NORTHEAST		
GREEN	PINE ACRES NURSI	NG HOME		MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 247	Findings include: On 11/28/16, at 6: shared a room with when he had pass facility's social wo that she could have loss of her spoused different room. His stated the SW tole away, but the rook kept a private rook did not happen, as the same day R84 R84 stated she fe a proper notice to time to adjust to the moving. R84's progress not 11/22/16, thru 11/2 that proper notice regards to R84's maddition, R84's maddi	ovide 1 of 1 resident (R84) with change notification. 13 p.m. R84 stated she had the provided the response up until 11/22/16, sed away. R84 stated the response time to adjust to the prior to having to move into a lowever, on 11/25/16, R84 downward her that she had to move right me she was moving into would be me for a while. R84 stated that is she received a roommate on a moved into the new room. It like she hadn't been provided move nor had she been given the loss of her husband prior to solves/social service notes from 25/16, lacked documentation had been provided to R84 with room change on 11/25/16. In edical record lacked a segarding Room Transfer	F 2	document a room change in the resident' semedical record. List Social Worker has documented change and followed up with Fedocument the status of her psewell-being after the room change well-being after the room change. New room change policy, effer 12/22/2016, will require the social department or designee to fact resident room changes in accept the Resident Bill of Rights and up documentation as needed specifically address those residered in the grieving process and any psychosocial effects of the change. Facility Room Change Notification Form will be updated used to document any resident changes. Systemic change will be assure requiring that the LSW or desicomplete the facility room change in the facility room change as this has been charted within the record. The notification form word of our ongoing system and will to the administrator at the conthe process. This form will semethod for ongoing auditing in The administrator will be respective.	censed of room R84 and will ychosocial age. ctive cial services ilitate ordance with to do follow and to dents who dents dent	
	resident disagreed Resident's Rights was reviewed and	04 p.m. the SW stated when a d with a room change, the Regarding Room Transfer form completed with the resident.		using this form to audit actual within the residents medical re All staff will be educated of ne The new policy will be implem	cords. w policy.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245563	B. WING			12/01/2016	
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G НОМЕ		4	TREET ADDRESS, CITY, STATE, ZIP CODE 27 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 247	provided a seven doccur. The resident seven day notice at time. The SW continue. The SW continue. The SW continue and time are seven day notice at time. The SW confirmed R84's merceived a new rood day she had moved confirmed R84's merceility's need to act The SW stated follow husband, R84 had some time to adjust moved into a different was a "little upset" verbal notice on 11, moved. The SW confirmed if the expecting the new shave allowed R84 to longer which would grieve the loss of his pending room charmedical record lack any discussions are when it had occurrent proposed room charactering (DON) we documenting R84's record and verified documentation regards.	change, the resident was ay notice that the move would at had the right to waive this and then could be moved at any firmed R84 had lost her 6, and had been moved into a ste room on 11/25/16, and had mmate on 11/25/16, the same of into her new room. The SW ove had been made due to the commodate a new admission. It is before she would have to be sent room. The SW stated R84 when he had given her a stated R84 when he had given her a stated R84 had not been ent Rights Regarding Room or to R84's room change. The se facility had not been admission, the facility would so stay where she was a little have given her more time to be generated as a little have given her more time to see spouse and adjusted to the seed documentation regarding bound R84's reaction to the large or how R84 had so new room and roommate. The either himself or the director were responsible for a room change in the medical and R84's medical record lacked arding any discussions around the entire thad occurred, R84's record had occurred, R84's record had occurred, R84's record had acclimated the entire thad occurred, R84's record had acclimated thad occurred, R84's record had acclimated thad occurred, R84's record had acclimated thad acclimated thad occurred, R84's record had acclimated thad acclimated thad acclimated thad acclimated that the size of how R84 had acclimated that the size of had acclimated that the size of how R84 had acclimated that the size of how R84 had acclimated that the size of how R84 had acclimated that the size of	F 2	247	the plan of correction will be integral into the quality assurance program evaluated for its effectiveness by the administrator during audits of residence conducted upon identifying residents with a room change form. The facility alleges that it will be in substantial compliance with the state indicated by January 4, 2017.	and ne ent J	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245563	B. WING _		12	/01/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464	, <u>-</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 247	Continued From p	age 5	F 24	7			
	was responsible for room change notice when a room charmon the DON confirms a resident was more in the resident's more werified R84 had be 11/25/16, and R84 documentation regime.	or p.m. the DON stated the SW or making sure the appropriate see was provided to residents age was requested or needed. The ded it was expected that anytime eved this would be documented edical record. The DON seen moved to a new room on seen moved to a new room on the seen moved to a					
	confirmed R84's n documentation that	6 a.m. the administrator nedical record lacked at proper notice had been rior to R84's room change on					
	indicated the resid consulted about the request would be of the transfer. In ad-	Room policy dated 10/12, lent and/or guardian must be the room transfer. The resident given consideration in making ldition, the following buld be recorded in the record:					
	 The title of the the transfer All assessmer move How the resident If the resident 	the room transfer occurred individual who assisted with at data obtained during the ent tolerated the move refused the move, the I the interventions taken					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464	
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F 247		ge 6 and title of the person	F 24	17	
F 279 SS=D	form dated 5/6/09, notified in writing, cand the justification than seven days be room within the fact 483.20(d), 483.20(l)	k)(1) DEVELOP	F 27	79	12/23/16
	to develop, review a comprehensive pla. The facility must de plan for each reside objectives and time medical, nursing, a	the results of the assessment and revise the resident's in of care. Evelop a comprehensive care ent that includes measurable stables to meet a resident's ind mental and psychosocial tified in the comprehensive			
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are ttain or maintain the resident's physical, mental, and leing as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.).			
	by:	NT is not met as evidenced and document review, the		It is the policy of Green Pine Acre	s that a

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		SURVEY PLETED	
		245563	B. WING	·····	12/0	01/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464			1 12/0/12010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	facility failed to de management care	velop a behavioral plan for 1 of 1 resident (R85) behaviors which were not	F 279	comprehensive care plan when individualized and meets the medical, nursing, mental, an psychological needs.	resident□s		
	Findings include:	Report dated 12/1/16, indicated		R85 s care plan was revise by RN unit manager and edu provided to this RN, who was 11/30/16.	ıcation was		
	Alzheimer's Disea admission diagnos R85's quarterly MI	se was R85's primary		Nursing and Social Services educated regarding this procrole in the process of develo individualized, comprehensive which includes behaviors (if that resident).	ess and their ping an e care plan		
	directed toward of pushing, scratchin sexually) 4 to 6 da but less than daily admission MDS in	hers (e.g., hitting, kicking, g, grabbing, abusing others ys in the assessment period, . This is an increase from R85's which this behavior was not IDS also indicated R85 had		Monthly behavior meetings, date 1/4/2017, will discuss a with behaviors based on behaviors □ notes. Social servic group regarding behaviors □ into MDS and these are to □ by the RN unit manager and revised if necessary.	Il residents navior notes in ses will inform eing entered e investigated		
	and subsequent g refusal of care and	are plan lacks identification of, oals and interventions for, daggressive or physically towards caregivers.		To assure behaviors will be appropriately the electronic behaviors will prompreport all behaviors to cart nucleus.	pehavior ot NARs to urse/TMA to		
	admission revealed behaviors directed -10/17/16: R85 free cares, resistive with	ehavior progress notes since d the following refusals and I to care: quently refused oral and peri th cares, verbally and ould strike out, hitting staff and		document what is reported a interventions if still requiring or additional assistance if ne services is to review these n gathering information for MD unit manager if not in care plat to a conference	and assist with intervention beded. Social otes when os and notify an.		

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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COI 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		•		
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	staff, and refused always watching e -11/9/16: R85 was attempted to take change her brief, F Review of the nurs nursing station revibehavior document Review of R85's Prevealed the follow by nursing assistant he behavior occur of occurrences on August 2016 -refused peri cares September: -Refused toileting -Physically abusive Cefused dressing -Verbally abusive Cefused dressing -Verbally abusive Cefused ly abusi	wandering, yelling and hitting cares. Res stated, "everyone is verything I do." incontinent of urine staff her to the bathroom, and R85 was hitting staff. sing assistant book at the ealed a blank page labeled station notes. oint of Care documentation ving behaviors were recorded ints (documentation indicated if tred on a shift, not the number a shift): sone shift one shift on sone shift on four shifts on two shifts	F 279	are entered into MDS and of these in Multidisciplinary cassessment. A progress not completed regarding outcordiscussion with the IDT. Unter then update care plan, if not the quality assurance provided for its effectivents services who will review be documentation daily for one then weekly x 4 weeks and ongoing at behaviors will be communicated with IDT. Effective also be evaluated by DON who will conduct random any plans weekly x3, then montain auditing behavior meet with care plans for follow up and submitting reporting to to maintain compliance. The facility alleges that it we substantial compliance with indicated by January 4, 201	are conference of will also be me of hit manager will accessary. The integrated program and easy by social havior emonth and monthly easy. Any endits of care chly x3 months ting minutes of as necessary administrator will be in the standard		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 279	-Refused oral care -Screaming, yelling -Verbally abusive of	es on two shifts g, excessive noise on two shifts	F 27	9			
	administrator (TM/	00 a.m. trained medication A)-A stated she knew how to naviors because of experience					
	(NA)-D stated R85 cares. NA-D also	10 a.m. nursing assistant struck out at staff and refused stated she knew how to naviors because of experience					
	nurse (LPN)-A startracked behavior at the NA's would let interventions would however, she did rewould have to look the surveyor ask the	:26 a.m. licensed practical ted the nursing assistants and if there was anything bad her know. LPN-A stated d be in R85's care plan, not know what they were and them up. LPN-A suggested he NA's about R85's behaviors, re additional information.					
	(RN)-B stated she these behaviors rathed witnessed resknow about the other about these which was an ongoinformation on res	14 p.m. registered nurse did not know R85 was having ather, knew R85 wandered and istance to eating, but did not her behaviors. RN-B had not behaviors in report either, oing way of gathering idents. RN-B stated if oted there would be an order for					

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	PROVIDER OR SUPPLIER	IG HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464			,	
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F 279	behavior monitoring	age 10 g. RN-B confirmed she did not ring these behaviors and had ould have investigated.	F 27	9			
	reviewed R85's red they had identified and not physical ab option. RN-B state	2 a.m. RN-B stated she had corded behaviors with staff and them as more "aggression" buse, but that was not an ed if the MDS nurse or the ght behaviors were a problem er.					
	documented by the facility social worker	a.m. RN-D stated behaviors NA's were reviewed by the rand the social worker MDS. This occurs prior to conference.					
	(DON) confirmed F assessment of her	B a.m. the director of nursing R85 did not have an behaviors nor was a an developed related to the					
		2 a.m. via telephone, the social rmed R85's behaviors should d.					
	and Monitoring poli 2015), indicated inti individualized and p	oral Assessment, Intervention icy (Med-Pass 2001, revised terventions would be part of an overall care upported physical, functional					

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE APPROPRIED	D BE	(X5) COMPLETION DATE
F 282 SS=D	and psychosocial nunderstand, prever distress or loss of a include, at a minim behavioral symptor intensity, duration, environment and p situations, targets a for the behavior an and specific and m targeted behaviors for effectiveness of 483.20(k)(3)(ii) SEI PERSONS/PER Commust be provided by the services provided to the services provided to the services of the servi	needs, and strives to at or relieve the resident's abilities. The care plan would um, a description of the ms including frequency, outcomes, location, recipitating factors or and individualized interventions d/or psychosocial symptoms easurable goals for the and how the staff will monitor if the interventions.	F 28			12/23/16
	by: Based on observa review, the facility f provided as directe resident (R50) obse was dependent on care. Findings include: R50's Diagnosis Re R20 was diagnose	NT is not met as evidenced tion, interview and document failed to ensure oral care was ad by the care plan for 1 of 1 erved for morning cares who staff for assistance with oral eport dated 11/20/16, indicated d with Alzheimer's disease, depression, and gastro-reflux		It is the policy of Green Pine Acre provide good oral hygiene for all rein order to prevent infection, irritat tooth decay, and also to moisten remembranes and prevent odor. Policy regarding oral cares was reand revised on 12/21/16. Care plan for R50 was updated to possibility of refusal and steps statake if this were to occur. Staff meetings to be held to discus residents in the facility who refuse	esidents ion, nucous viewed reflect ff are to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTION	` '	SURVEY PLETED
		245563	B. WING _			12/0	01/2016
	PROVIDER OR SUPPLIER	G HOME		427 N	ET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET NORTHEAST AHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	required total assist grooming and physicares using a tooth. The current nursing directed staff to physicares using a tooth. On 11/30/16, at 7:2 bed with night cloth back touching and curtain. On 11/30/16, at 8:1 (NA)-E and NA-F wroom and provide in	ted 11/20/16, indicated R50 tance with dressing and ical assist of one staff with oral brush twice a day. g assistant assignment report vsically assist R50 with oral brush twice a day. 5 a.m. R50 was observed in es on, awake, laying on his holding on to the privacy 6 a.m. nursing assistants were observed to enter R50's norning cares. The NA's were	F 28	E N ec up Ja A T an in po et c x x m po bo re	are and care plans to be updated necessary. ducation was provided to NA-F ar A-E on 12/21/16. NARs will be producation regarding the procedure pdated policy for oral cares prior to anuary 4, 2016. Il staff will be educated of revised he revised policy will be implement the plan of correction will be attegrated into the quality assurance rogram and evaluated for its effectiveness by the DON or design the will perform randomized be be be be be be be a will be completed twice a week on different amonths. Observational audits what in compliance that the care is the rovided. Audits and findings will be rought to QA meeting. Education egarding oral hygiene and refusal	d on this and provided re and re to ad policy. ented nce gnee, ent shifts will e is being be	
	the wheel chair with removed R50's low denture cup on the them in R50's mout became slightly agi sometimes refused the second failed at partials back in the had no upper teeth some teeth on the lows a partial plate.	a.m. R50 was transferred to a mechanical lift. NA-E er dental partial from a sink and attempted to put th. R50 was not accepting and tated. NA-F stated R50 had to wear the dentures. After ttempt, NA-E put the dental denture cup. NA-E stated R50 and no upper denture but had bottom and that was why it NA-E proceeded to shave the resident out of the room		N T sı	ares will be discussed yearly with AR□s annual evaluation. he facility alleges that it will be in ubstantial compliance with the standicated by January 4, 2017.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245563	B. WING _		12	/01/2016		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 282	On 11/30/16, at 8: had not provided FR50's teeth should mouth should have the toothette's beforeom. On 11/30/16 at 8:5 teeth were not brucleaned before or partial dentures in On 12/1/16, at 10: (RN)-F verified R5 brush teeth two timesident had a hist inform the RN so to into place. RN-F sand should be donor The facility Oral Hynoted it was the pogood oral hygiene prevent infection, it oral hygiene is also membranes and to	50 a.m. NA-F confirmed she R50 oral hygiene and stated I have been brushed or the etat least been swabbed with ore R50 was taken to the dining 2 a.m. NA-E confirmed R50's shed or the mouth was not after she attempted to put the place. 11 a.m. registered nurse 0's care plan directed staff to nes a day. RN-F added, if a ory of refusing the staff were to that another plan could be put stated oral cares were important.	F 28	2				
	the care plan shall care based on the prescribed and lon include the physici treatment, diet, an	be a personalized plan of daily nature of illness, treatment g and short term goals. It shall an's orders for medications, d other therapy. It shall of care needed and how they						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245563	B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME	'	STREET ADDRESS, CITY, STATE, ZIP CODE 127 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	meet the residents' 483.25 PROVIDE (HIGHEST WELL BEach resident mus provide the necessor maintain the highmental, and psychological).	plished, and how the plans needs. CARE/SERVICES FOR	F 282			12/23/16
	by: Based on observa review, the facility f behavioral manage residents (R85) wh	NT is not met as evidenced tion, interview and document failed to implement a ement program for 1 of 1 o had behavior symptoms, an ses and was reviewed for otional status.		It is the policy of Green Pine Acres comprehensive care plan which is individualized and meets the resider medical, nursing, mental, and psychological needs. R85□s care plan was revised on 11 by RN unit manager and education provided to this RN, who was involv 11/30/16.	nt⊡s /30/16 was	
	Alzheimer's Diseas admission diagnos R85's quarterly Mir 11/9/16, indicated F behavioral symptor (e.g., hitting, kickingrabbing, abusing of	eport dated 12/1/16, indicated se was R85's primary is. nimum Data Set (MDS) dated R85 exhibited physical ms directed toward others g, pushing, scratching, others sexually) 4 to 6 days in ent period, but less than daily.		Nursing and Social Services will be educated regarding this process and role in the process of developing an individualized, comprehensive care which includes behaviors (if needed that resident). Monthly behavior meetings, next medate 1/4/2017, will discuss all reside with behaviors based on behavior murses□ notes. Social services will in	plan I for eeting ents otes in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	SURVEY PLETED
		245563	B. WING		12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				427 MAIN STREET NORTHEAST		
GREEN I	PINE ACRES NURSIN	NG HOME		MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pa	age 15	F 30	9		
	in which this behav	ase from R85's admission MDS vior was not exhibited. R85's d R85 had severely impaired		group regarding behaviors into MDS and these are to by the RN unit manager ar revised if necessary.	be investigated	
	subsequent goals	cked identification of, and and interventions for, refusal of we or physically abusive caregivers.		To assure behaviors will be appropriately the electronic charting for NARs will pron report all behaviors to cart document. The cart nurse/document what is reported	c behavior npt NARs to nurse/TMA to TMA is then to I and assist with	
		ehavior progress notes since d the following refusals and to care:		interventions if still requirin or additional assistance if r services is to review these gathering information for N	needed. Social notes when IDS and notify	
	-10/17/16: R85 frequently refused of cares, resistive with cares, verbally physically. R85 would strike out, his hollering at them. Staff needs to lead again and try11/6/16: R85 was wandering, yelling staff, and refused cares. Resistated always watching everything I do." -11/9/16: R85 was incontinent of uri			unit manager if not in care At quarterly care conference Services will address any to are entered into MDS and these in Multidisciplinary ca assessment. A progress no completed regarding outco discussion with the IDT. Un then update care plan, if no	ce, Social cehaviors that document are conference ote will also be ome of nit manager will	
		her to the bathroom, and		The plan of correction will into the quality assurance evaluated for its effectiveneservices who will review be	program and ess by social	
		sing assistant book located at revealed a blank page labeled station notes.		documentation daily for on then weekly x 4 weeks and ongoing at behavior meeting changes in behaviors will be	e month and I monthly ngs. Any pe	
	revealed the follow by nursing assista	oint of Care documentation ving behaviors were recorded nts (documentation indicated if rred on a shift, not the number a shift):		communicated with IDT. E also be evaluated by DON who will conduct random a plans weekly x3, then mon and auditing behavior mee with care plans for follow u	or designee, ludits of care thly x3 months ting minutes	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVEY COMPLETED		
		245563	B. WING			12/	01/2016
	PROVIDER OR SUPPLIER	G НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464			·v . v
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	August 2016 -refused peri cares September: -Refused toileting of -Physically abusive October: -Refused oral cares -Refused toileting of -Refused dressing -Verbally abusive of -Physically abusive -Screaming, yelling November: -Refused toileting of -Physically abusive -Refused oral cares -Screaming, yelling -Verbally abusive of -refused an unspect On 11/29/16, at 3:4 walking down the higher down the higher down	one shift one shift one shift one shift on four shifts on two shifts on two shifts on two shifts on two shifts on six shifts on six shifts on six shifts on six shifts on one shift on one shift sified care on one shift. 9 p.m. R85 was observed allway, replied hello when her day was going pretty 2 p.m. R85 was observed by the Birchwood nursing ong a tissue in her hand. At 4:37 and began walking down the		809	and reporting to administrator to macompliance. The facility alleges that it will be in substantial compliance with the staindicated by January 4, 2017.		
	On 11/29/16, at 5:3	7 p.m. R85 was observed in					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245563	B. WING			12/	01/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME		42	TREET ADDRESS, CITY, STATE, ZIP CODE 27 MAIN STREET NORTHEAST IENAHGA, MN 56464	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	the dining room, ar on a couch by the I	age 17 nd then she left and went to sit Birchwood nursing station. At dered back into the dining	F 3	09			
	seated on a couch station with a cover napkin. At 8:19 a.m	2 a.m. R85 was observed near the Birchwood nurses red beverage cup and a n., R85 was observed walking ner husband's hand.					
	administrator (TMA	0 a.m. trained medication a)-A stated she knew how to aviors because of experience					
	(NA)-D stated she behaviors because her. NA-D stated si the point of care ar	0 a.m. nursing assistant knew how to manage R85's of experience working with he charted certain behaviors in ind in a book at the nurses d R85 would strike out at staff					
	nurse (LPN)-A state tracked behaviors a the NA's would let interventions would however, she did n them up. LPN-A su	26 a.m. licensed practical ed the nursing assistants and if there was anything bad, her know. LPN-A stated I be in R85's care plan ot know them without looking ggested the surveyor ask the behaviors, as she did not have on.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245563	B. WING			12/	01/2016
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		12/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From page 18 On 11/30/16, at 3:14 p.m. registered nurse (RN)-B stated she did not know how resident behaviors listed in the lookback report were recorded or by whom. RN-B stated cart nurses recorded behaviors in a progress note and supposed the behaviors listed on the reports were entered by the NAs. RN-B stated she did not know R85 was having these behaviors rather she knew R85 wandered and had also witnessed R85's resistance to eating but did not know about the other behaviors. RN-B stated she had not heard about these behaviors in report either, which was an ongoing way of gathering information on residents. RN-B stated if behaviors were noted there would be an order for behavior monitoring and confirmed she did not know R85 was having these behaviors, if she had know she would have investigated them. On 11/30/16, at 3:27 p.m. NA-A stated she entered resident behaviors on to the point of care documentation system and also informed the nurse.			809			
	behaviors on the partner nurse. NA-B show to record behaviors.	28 p.m. NA-B stated she enters point of care system and tells tated they have had training on naviors, but it has been a while.					
	entered resident by system and inform	29 p.m. NA-C stated she behaviors on the point of care ned the cart nurse. NA-C stated all type a progress note as well.					
		32 a.m. RN-B stated she had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245563	B. WING		12	/01/2016	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	physical abuse, but the documentation MDS nurse or the s behaviors were a p	as more "aggression" and not that was not an option within system. RN-B stated if the social worker thought roblem they would notify her.	F 3	09			
	documented by the facility social worke	a.m. RN-D stated behaviors NA's were reviewed by the r and the social worker MDS which occurs prior to conference.					
	(DON) stated the N behaviors and reports and reports and reports at the documentation side progress notes, it does not as many nursing not be happening and so behavior, it should a manager. The DON were also noted in reports during which decide if there was intervention. The D have an assessment planned intervention.	a.m. the director of nursing As should document int to the nurse. The DON In't compare the NA's by side with the nursing id appear as if there were not otes as behaviors documented ON confirmed that both should stated depending on the also be reported to the unit I stated resident behaviors the morning and afternoon the time a unit manager could a pattern and a need for ON confirmed R85 did not ont of her behaviors nor care ans for the recorded behaviors. The facility social worker pulled the determine the sessments.					
	social worker stated	a.m. via telephone, the facility d he gathered behavior e look back reports (nursing					

[`` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245563	B. WING		12	/01/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME		STREET ADDRESS, CITY, STATE, ZIP COD 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	assistant data) and nurse narratives) a information from the but there was not at The social worker's related to refusing admitted to the facing discussed at R85's. Review of R85's monote revealed no note identification, assessinterventions, and the one care confective was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect that was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as that we information in the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was not reflect R85's behaviors shadiscussed as the social was	the progress notes (licensed nd also gathered some e book at the nursing station, whole lot of information there stated R85 had behaviors that care which was why she was ility and these behaviors were care conference.	F 3	09		
	and Monitoring poli 2015), indicated the evaluate new or chin order to identify any modifiable fact. The policy further in-Interventions woul an overall care enviphysical, functional strives to understar resident's distress c-The care plan wouldescription of the birequency, intensity	d be individualized and part of ironment that supports and psychosocial needs, and nd, prevent or relieve the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		X3) DATE SURVEY COMPLETED	
		245563	B. WING		2/01/2016	
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 127 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 309	for the behavior an -Specific and meas behaviors and how effectiveness of the	and individualized interventions d/or psychosocial symptoms surable goals for the targeted the staff would monitor for e interventions.	F 309		40/00/40	
SS=D	DEPENDENT RES A resident who is u daily living receives	CARE PROVIDED FOR SIDENTS nable to carry out activities of sithe necessary services to ition, grooming, and personal	F 312		12/23/16	
	by: Based on observa review, the facility t provided for 1 of 1 morning cares who	NT is not met as evidenced tion, interview and document o ensure oral care was resident (R50) observed for was dependent on staff for al care which was not provided care plan.		It is the policy of Green Pine Acres to provide good oral hygiene for all residen in order to prevent infection, irritation, tooth decay, and also to moisten mucou membranes and prevent odor. Policy regarding oral cares was reviewed and revised on 12/21/16.	1	
	R20 was diagnose vascular dementia R50's annual Minin 11/16/16, indicated impairment, was to	eport dated 11/20/16, indicated d with Alzheimer's disease, and gastro-reflux disease. num Data Set (MDS) dated R50 had severe memory tally dependent on staff for all ring and required full physical		Care plan for R50 was updated to reflect possibility of refusal and steps staff are to take if this were to occur. Staff meetings to be held to discuss other residents in the facility who refuse oral care and care plans to be updated on the if necessary. Education was provided to NA-F and NA-E on 12/21/16. NARs will be provide education regarding the procedure and	o er s	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
		245563	B. WING			12/0	1/2016
	PROVIDER OR SUPPLIER	G НОМЕ		42	TREET ADDRESS, CITY, STATE, ZIP CODE 7 MAIN STREET NORTHEAST 1ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	care. The MDS also cavities or broken to the R50's Dental Care 11/10/16, indicated down at gum line to missing teeth. The received total assis grooming and physicares using a tooth. The current nursing directed staff to physicares using a tooth. On 11/30/16, at 7:2 bed, with night cloth on his back touchin privacy curtain.	Area Assessment dated R50 had obvious eeth. Area Assessment dated R50 had one tooth broken oward back and several assessment noted R50 at for oral cares. Area Assessment dated R50 had one tooth broken oward back and several assessment noted R50 assessment noted R50 at for oral cares. Area Assessment dated R50 had one tooth broken oward back and several assessment noted R50 assessment noted R50 tance with dressing and brush twice a day. Area Assessment dated R50 had obvious	F3	12	updated policy for oral cares prior to January 4, 2016. All staff will be educated of revised prices of the revised policy will be implement and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the DON or designe who will perform randomized observational audits which will be completed twice a week on different x3 months. Observational audits with maintain compliance that the care is provided. Audits and findings will be brought to QA meeting. Education regarding oral hygiene and refusal of cares will be discussed yearly with example and the provided and all the provided provided and the provided provid	policy. ted ee, t shifts ill s being e of oral	
	observed to wash a approximately 8:40 the wheelchair via a removed R50's low denture cup on the them in R50's mou	and dress R50 and at a.m. R50 was transferred to a mechanical lift. NA-E rer dental partial from a sink and attempted to put th. R50 was not accepting and itated. NA-F stated R50 had					

CORRECTION	IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	. ,	TE SURVEY MPLETED
	245563	B. WING _		12	/01/2016
			STREET ADDRESS, CITY, STATE, ZIP C 427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE
ometime refused econd failed atter artials back in the ad no upper teetlome teeth on the as a partial plate as a partial dense before on a 11/30/16, at 8.50 as the resident work as the properties as the resident work as the resident work as the resident work as the resident two times as the resident to the total as the resident work as the resident work as the resident two times as th	to wear the dentures. After the mpt, NA-E put the dental e denture cup. NA-E stated R50 in and no upper denture but had bottom and that was why it. NA-E proceeded to shave R50 to the dining room. So a.m. NA-F confirmed she boral hygiene for R50 and stated if have been brushed or the etat least been swabbed with bore R50 was taken to the dining shed or the mouth was not after she attempted to put the place. To a.m. R50 was observed to the dining room after breakfast, is mouth could not be visualized build not open the mouth. To a.m. registered nurse so's care plan directed staff to ones a day. RN-F added, if	F 31	,		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR continued From pometime refused econd failed attered artials back in the ad no upper teetl ome teeth on the as a partial plate 50 then wheeled n 11/30/16, at 8 ad not provided of 50's teeth should outh should have the toothettes before or artial dentures in n 11/30/16, at 9: wheeled out of the inside of R50's the resident wo n 12/1/16, at 10: RN)-F verified R5 rush teeth two times to the teeth two times on 12/1/16, at 10: RN)-F verified R5 rush teeth two times on 12/1/16, at 10: RN)-F verified R5 rush teeth two times on 12/1/16, at 10: RN)-F verified R5 rush teeth two times on 12/1/16, at 10: RN)-F verified R5 rush teeth two times	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 23 ometime refused to wear the dentures. After the econd failed attempt, NA-E put the dental artials back in the denture cup. NA-E stated R50 and no upper teeth and no upper denture but had ome teeth on the bottom and that was why it as a partial plate. NA-E proceeded to shave 50 then wheeled R50 to the dining room. In 11/30/16, at 8:50 a.m. NA-F confirmed she and not provided oral hygiene for R50 and stated 50's teeth should have been brushed or the outh should have at least been swabbed with the toothettes before R50 was taken to the dining from. In 11/30/16 at 8:52 a.m. NA-E confirmed R50's eith were not brushed or the mouth was not eaned before or after she attempted to put the artial dentures in place. In 11/30/16, at 9:10 a.m. R50 was observed to be wheeled out of the dining room after breakfast. The inside of R50's mouth could not be visualized as the resident would not open the mouth. In 12/1/16, at 10:11 a.m. registered nurse RN)-F verified R50's care plan directed staff to trush teeth two times a day. RN-F added, if	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 23 ometime refused to wear the dentures. After the econd failed attempt, NA-E put the dental artials back in the denture cup. NA-E stated R50 and oupper teeth and no upper denture but had ome teeth on the bottom and that was why it as a partial plate. NA-E proceeded to shave 50 then wheeled R50 to the dining room. In 11/30/16, at 8:50 a.m. NA-F confirmed she ad not provided oral hygiene for R50 and stated 50's teeth should have been brushed or the outh should have at least been swabbed with e toothettes before R50 was taken to the dining from. In 11/30/16 at 8:52 a.m. NA-E confirmed R50's eith were not brushed or the mouth was not eaned before or after she attempted to put the artial dentures in place. In 11/30/16, at 9:10 a.m. R50 was observed to be wheeled out of the dining room after breakfast. 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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		245563	B. WING	·····	12/01/	2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHGA, MN 56464	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE CO	(X5) DMPLETION DATE
	good oral hygiene prevent infection, in oral hygiene is also membranes and to	olicy of the facility to provide for all residents in order to critation and tooth decay. Good o done to moisten the mucous o help prevent odor.	F 31:		40	V/00 /4.0
	SPREAD, LINENS The facility must es Infection Control P safe, sanitary and to help prevent the of disease and infe (a) Infection Contro The facility must es Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied to (3) Maintains a rec actions related to in	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection. Of Program stablish an Infection Control ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and ord of incidents and corrective infections.	F 44		12	:/23/16
	determines that a reprevent the spread isolate the resident (2) The facility must communicable disc from direct contact direct contact will to (3) The facility must hands after each direct direct direct direct direct contact will to (3) The facility must hands after each direct dir	tion Control Program resident needs isolation to of infection, the facility must t. st prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. st require staff to wash their irect resident contact for which dicated by accepted				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245563	B. WING _		12/0	01/2016	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP (427 MAIN STREET NORTHEAST MENAHGA, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	transport linens so infection.	page 25 andle, store, process and page as to prevent the spread of ENT is not met as evidenced	F 44	11			
	by: Based on observer review, the facility storage of person equipment/tubing R52, R42, R6, R2 oxygen tubing lyir unclean surfaces from contamination to maintain a saniof 1 resident (R20)	ation, interview and document failed to maintain sanitary al resident oxygen for 6 of 6 residents (R2, R90, 15) observed to have nasaling on the floor or touching without a barrier for protection on. In addition, the facility failed tary and cleanable surface for 1 of observed to have a grab bar and taped on with duct tape		It is the policy of Green Pir provide an Infection Prever Control Program that provide sanitary, and comfortable eand to help prevent the deveransmission of disease and Hooks have been placed of concentrators for staff to us tubing when not in use. Resplans have been updated of residents who remove their tubing. Proper hygiene tech explained to those resident documented as well.	ntion and des as safe, environment velopment and id infection. In all oxygen se to wind up sident care on those r own oxygen nniques		
	(tubing device use nose) and oxyger	1:56 a.m. R2's nasal cannula ed to deliver oxygen through the tubing was observed ying on the floor in the resident's		All residents with oxygen w by RN unit managers prior care plans updated regardi ability to remove nasal can education provided and do care plan and nursing note	to 1/4/17 and ing resident⊡s nulas and cumented in		
	tubing was observed concentrator with	1:50 a.m. R90's nasal cannula yed draped over the oxygen the nasal cannula up he concentrator's electrical		Foam was removed from F bar. All resident rooms wer 12/21/16 and no uncleanable remain on any bed grab bat protect arms from bumping are to offer resident a pillownext to resident when in be	re checked on ble surfaces ars. If needed to g grab bars staff w to be placed		

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		SURVEY PLETED
		245563	B. WING _		12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP C		
				427 MAIN STREET NORTHEAST		
GREEN	PINE ACRES NURSI	NG HOME		MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441	On 11/30/16, at 11 was observed dra bed with the nasal floor touching the 8:36 a.m. R52's owas observed lyin. On 11/30/16, at 7: was observed dra concentrator with close to the floor. On 12/1/16, at 8:4 tubing was observed dra concentrator with back side of the concentrator with back side of the concentrator with back side of the concentrator with against a heating and on 12/01/16, at 7:	2:46 a.m. R52's oxygen tubing ped over R52's grab bar on the cannula lying directly on the waste basket. On 12/1/16, at xygen tubing and nasal cannula g directly on the floor. 43 a.m. R42's oxygen tubing ped over the oxygen the nasal cannula hanging 2 a.m. R42's nasal cannula red draped over the unmade	F 44	,	nable surfaces I cannulas. educated and surfaces com. This will is when eport to the unit asal cannulas. The updated to ng grab bars when in bed. In able included in the encluded in the encluded for its rooms for surfaces estings, with	
	On 12/1/16, 10:20 (DON) completed rooms and verified laying on the floor			Walk through for checks of will be done twice a week o shifts to identify and mainta DON or designee will audit infection meeting minutes a information documented to up has been completed and made as necessary.	oxygen tubing n different in compliance. monthly any assure follow	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245563	B. WING			12/	01/2016
	PROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 27 MAIN STREET NORTHEAST IENAHGA, MN 56464	,	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	cannula could at le concentrator. The nasal cannula's we	age 27 be wound up so the nasal east hang on the knobs of the DON stated the tubing and ere not being stored in a ut was not certain what the	F 4	41	The facility alleges that it will be in substantial compliance with the staindicated by January 4, 2017.	andard	
	Grab Bars						
	observed equipped were covered with	at 11:05 a.m. R20's bed was uipped with bilateral grab bars which d with grey foam and dark duct tape d an uncleanable surface.					
	(RN)-F stated she grab bars covered the facility was to he their grab bars becclean or sanitize the grab bars were covered.	45 a.m. registered nurse was not aware any one had in foam. RN-F stated no one in have foam and duct tape on cause there was no way to be foam. RN-F verified R20's evered with foam and duct tape ow long they had been that					
	oxygen would be a administered by ox while in building. A provided and indicate changed every	n Policy, dated 6/12, indicated evailable for residents and be exygen concentrator or tank in undated cleaning policy was ated Oxygen Cannula's were to two weeks and as needed. The icate how the cannula's and stored.					
	A grab bar policy re	elated to cleaning and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED			
		245563	B. WING		12	/01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 441	Continued From p sanitization was n		F 4	41		

F5563024

PRINTED: 01/04/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0		(X3) DATE SURVEY COMPLETED	
		245563	B. WING		11/	29/2016
	PROVIDER OR SUPPLIER	G HOME	42	REET ADDRESS, CITY, STATE, ZIP COI 7 MAIN STREET NORTHEAST ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY					
	Minnesota Departn Fire Marshal Division Green Pine Acres Naubstantial complian participation in Med Subpart 483.70(a), 2012 edition of Nath Association (NFPA	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Nursing Home was found not in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety ter 19 Existing Health Care.		22		
	ALLEGATION OF ODEPARTMENT'S ASSIGNATURE AT THE PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN OTHER YOUR VERIFICATION.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		EPO	C	
	HEALTH CARE FII STATE FIRE MAR: 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145				
	By e-mail to:					

(6) DATE

Electronically Signed

12/23/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/	29/2016
	PROVIDER OR SUPPLIER	IG HOME		427	EET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET NORTHEAST NAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@s and Angela.Kappenmark THE PLAN OF CO DEFICIENCY MUSTOLLOWING INFO 1. A description of to correct the deficion of the correct the deficient of the correct the correct the correct the correct the deficient of the correct the co	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. or title of the person rection and monitoring to ence of the deficiency. en inspected as one building, 2016 both buildings are		000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	,	TIPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY PLETED
		245563	B. WING		11/3	29/2016
	PROVIDER OR SUPPLIER	IG HOME		STREET ADDRESS, CITY, STATE, ZIP (427 MAIN STREET NORTHEAST MENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 2	ΚO	00		
	sprinkler system. Talarm system with corridors and space monitored for auto notification. The facility has a li	s protected by a complete fire the facility has a complete fire smoke detection in the es open to the corridor that is matic fire department censed capacity of 65 beds of 62 at the time of the survey.				
	NOT MET as evide	t 42 CFR Subpart 483.70(a) is enced by: er System - Maintenance and	K 3	53		12/23/16
	Automatic sprinkle inspected, tested, with NFPA 25, Star Testing, and Maint Protection System maintenance, insperior maintained in a seavailable.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked		3		
	b) Who provided					
	c) Water system					
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, This STANDARD	is not met as evidenced by:				
		tion and staff interview, the intain the sprinkler system in		It is the policy of Green Pi maintain automatic sprinkl		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ' ' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245563	B. WING			11/2	9/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	IG HOME		42	REET ADDRESS, CITY, STATE, ZIP CODE 7 MAIN STREET NORTHEAST ENAHGA, MN 56464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
K 353	(NFPA 101) and NF standard for testing systems. This defic sprinkler system not allow for the spread 62 residents and at staff and visitors. Findings include: On the facility tour pm on 11-29-2016 interview revealed replaced when the turned from red to are, one in the kitcl room 354A, and or This deficient cond	age 3 e 2012 Life Safety Code FPA 25 section 5.2.1.1.2. The g and maintenance of sprinkler cient condition could cause the oft to function properly and d of fire. This could affect 29 of n undetermined amount of between 12:00 pm and 4:00 observations and staff 3 sprinkler heads were not fluid in the frangible bulbs yellow or clear. The locations hen freezer, one in shower he in soiled utility room 473. ition was confirmed by the or and the Maintenance	К3	353	reliable operating condition and to periodically. The sprinkler heads in the kitcher shower room 354A, and soiled uti 473, have an orange colored liqui. After further investigation by the maintenance supervisor, it was determined that the orange liquid that the sprinkler head has differe sensitivity than the red colored liquing orange liquid bulb has a heat sens temperature of 135 degrees while is 155 degrees. Conversation with Summit, our fir system company, verified the oral colored sprinkler head is adequated protection as long as the two color not located in the same room. A verthrough check completed 12/21/2 the maintenance supervisor and administrator assured that the oral red colored sprinkler head bulbs a separated by a fire door and are relocated in the same room.	n freezer, lity room d bulb. means on theat uid. The sitive enthe red e alarm nge e walk on the by ange and are	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted December 14, 2016

Ms. Laura Ahlf, Administrator Green Pine Acres Nursing Home 427 Main Street Northeast Menahga, MN 56464

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5563027

Dear Ms. Ahlf:

The above facility was surveyed on November 28, 2016 through December 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Green Pine Acres Nursing Home December 14, 2016 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/28/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
		00070	B WING		40/0	4/0040
		00678			12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME	I STREET NO 6A, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depart					
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/23/16

TITLE

PRINTED: 01/30/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00678 12/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **427 MAIN STREET NORTHEAST GREEN PINE ACRES NURSING HOME** MENAHGA, MN 56464 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

INITIAL COMMENTS:

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/23/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00678	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	GHOME	STREET NO A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure procompletion date, th corrected prior to e Minnesota Department on November 28, surveyors of this Deabove provider and orders are issued. electronic plan of creviewed these ord they will be comple Minnesota Department of the State Licensing federal software. The State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of complete the statement of the	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 29, 30 and December 1, 2016, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. The following correction Orders using ag numbers have been sota state statutes/rules for the opportunity of the state statute ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes th	2 000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00678	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 5646	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
2 000 2 430	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA! THERE IS NO REC PLAN OF CORREC MINNESOTA STAT	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.	2 000			1/4/17
	A nursing home muresident's preference roommates, and fur This MN Requirements	assignments and furnishings. Just attempt to accommodate a sees on room assignments, rnishings whenever possible. Just attempt to accommodate a sees on room assignments, rnishings whenever possible.		It is the policy of Overs Dine Asys	•	
	facility failed to provappropriate room classification of the second states of the second sta	and document review, the ride 1 of 1 resident (R84) with hange notification. 3 p.m. R84 stated she had her spouse up until 11/22/16, d away. R84 stated the er (SW) had initially told R84 some time to adjust to the prior to having to move into a vever, on 11/25/16, R84 her that she had to move right she was moving into would be for a while. R84 stated that		It is the policy of Green Pine Acres document a room change in the resident s medical record. License Social Worker will document room and follow up with R84 and docume status of her psychosocial well-bein the room change. New room change policy, effective 12/22/2016, will require the social sidepartment or designee to facilitate resident room changes in accordant the Resident Bill of Rights and to do up documentation as needed and to specifically address those residents are in the grieving process and wat any psychosocial effects of the room change. Facility Room Change Not Form will be updated and used to	ed change ent the ng after services ence with o follow o s who ich for m	

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00678	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	the same day R84 R84 stated she felt a proper notice to n	she received a roommate on moved into the new room. like she hadn't been provided nove nor had she been given e loss of her husband prior to		document any resident room chan Systemic change will be assured a requiring that the LSW or designe complete the facility room change notification form that includes date notification of the resident and fan regarding the room change as we	e, time of	
	R84's progress notes/social service notes from 11/22/16, thru 11/25/16, lacked documentation that proper notice had been provided to R84 with regards to R84's room change on 11/25/16. In addition, R84's medical record lacked a Residents' Rights Regarding Room Transfer form.			this has been charted within the m record. The notification form will be of our ongoing system and will be to the administrator at the complete the process. This form will serve a method for ongoing auditing in rea The administrator will be responsitiving this form to audit actual cha within the residents medical record All staff will be educated of new positive.	edical pe part routed ion of ss a I time. ple for rting ds.	
	On 11/30/16, at 2:04 p.m. the SW stated when a resident disagreed with a room change, the Resident's Rights Regarding Room Transfer form was reviewed and completed with the resident. This form indicated if the resident disagreed with the proposed room change, the resident was provided a seven day notice that the move would occur. The resident had the right to waive this seven day notice and then could be moved at any time. The SW confirmed R84 had lost her spouse on 11/22/16, and had been moved into a			The new policy will be implemented the plan of correction will be integrinto the quality assurance program evaluated for its effectiveness by the administrator during audits of residence conducted upon identifying residents with a room change form The facility alleges that it will be in substantial compliance with the stain indicated by January 4, 2017.	d and rated n and he dent g	
	received a new roo day she had moved confirmed R84's me facility's need to act The SW stated follohusband, R84 had some time to adjus moved into a difference was a "little upset" verbal notice on 11/2	te room on 11/25/16, and had mmate on 11/25/16, the same d into her new room. The SW ove had been made due to the commodate a new admission. Owing the death of her asked him if she could have to be the toom. The SW stated R84 when he had given her a 1/25/16, that she had to be erified R84 had not been				

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	NT OF DEFICIENCIES I OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
				7.1. 20.23.110.			
		00678		B. WING		12/0	01/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME		STREET NO A, MN 5646			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 430	Continued From particles of the expecting the new have allowed R84 tonger which would grieve the loss of high pending room charmedical record lack any discussions are when it had occurre proposed room charmedical record acclimated to R84's. The SW confirmed of nursing (DON) with documenting R84's record and verified documentation reg. R84's room change reaction to the move to her new room are common to the poon common to the poon common to the resident was mover in the poon confirmed a resident was mover in the poon confirmed a provided appropriation of 12/1/16, at 8:46 confirmed R84's medocumentation that documentation that the provided appropriation of the provided appropriation to the provided appropriation that the provided appropriation	ent Rights Ror to R84's roe facility had admission, the ostay where have given er spouse and ge. The SW and document ound R84's read ge or how a new room a either himse aroom chang I R84's medical arding any de, when it have, or how Rad roommater of p.m. the Dramaking sure was provided it was experted this would be arding if R84 arding	corn change. The not been the facility would as she was a little her more time to ad adjusted to the verified R84's attation regarding coom change, action to the R84 had and roommate. The director sible for ge in the medical cal record lacked iscussions around doccurred, R84's R84 had acclimated according to the director sible for ge in the medical cal record lacked iscussions around doccurred, R84's R84 had acclimated according to the appropriate led to residents ested or needed. The DON of a new room on cord lacked had been the room change.	2 430			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00678	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 430	Continued From pa	ge 5	2 430			
	11/25/16.					
	indicated the reside consulted about the request would be g the transfer. In add	lld be recorded in the				
	 The title of the the transfer All assessment move How the reside If the resident reason(s) why and 	the room transfer occurred individual who assisted with a data obtained during the ont tolerated the move efused the move, the the interventions taken and title of the person				
	form dated 5/6/09, notified in writing, o and the justification	Regarding Room Transfers indicated residents must be f a proposed room transfer of the room transfer no later fore the transfer to another ility.				
	director of nursing with the social work and procedures for of room/roommate educate staff. The	THOD OF CORRECTION: The (DON) or designee could work ter/designee to update policies when to notify the resident(s) changes, and then could DON or designee could also esident records to determine if				

Minnesota Department of Health

STATE FORM 0T1M11 If continuation sheet 6 of 32

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00678	B. WING		12/0 ⁻	1/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOMF	STREET NO A, MN 5646	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
2 430	Continued From pa	ge 6	2 430			
	the resident(s) had been notified as appropriate.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			1/4/17
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The comust include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to deve management care p who had displayed identified on the car	plan for 1 of 1 resident (R85) behaviors which were not		It is the policy of Green Pine Acres comprehensive care plan which is individualized and meets the reside medical, nursing, mental, and psychological needs. R85 s care plan was revised on 11 by RN unit manager and education	ent s 1/30/16 was	
		eport dated 12/1/16, indicated e was R85's primary s.		provided to this RN, who was involved 11/30/16. Nursing and Social Services will be educated regarding this process and role in the process of developing are individualized, comprehensive care which includes behaviors (if needed)	nd their n n e plan	
		S dated 11/9/16, indicated ical behavioral symptoms		that resident). Monthly behavior meetings, next m date 12/29/2016, will discuss all res	eeting	

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00678	B. WING		12/01/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME 427 MAIN	DRESS, CITY, STREET NO A, MN 5646		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
2 560	pushing, scratching sexually) 4 to 6 day but less than daily. admission MDS in exhibited. R85's ME severely impaired of the result of the resu	ers (e.g., hitting, kicking, grabbing, abusing others in the assessment period, This is an increase from R85's which this behavior was not DS also indicated R85 had ognition. The plan lacks identification of, als and interventions for, aggressive or physically owards caregivers. That is an increase from R85's which this behavior was not DS also indicated R85 had ognition. The plan lacks identification of, als and interventions for, aggressive or physically owards caregivers. That is a plan lacks identification of, als and interventions for, aggressive or physically owards caregivers. That is a plan lacks identification of, als and interventions for, aggressive or physically owards caregivers. The following refusals and to care: The following refusals and perion of cares, verbally and uld strike out, hitting staff and that in the perion of the perion o	2 560	with behaviors based on behavior nurses notes. Social services will group regarding behaviors being e into MDS and these are to be investigated by the RN unit manager and care prevised if necessary. To assure behaviors will be docume appropriately the electronic behavior charting for NARs will prompt NAR report all behaviors to cart nurse/TMA is a document. The cart nurse/TMA is a document what is reported and assinterventions if still requiring interveror additional assistance if needed. services is to review these notes we gathering information for MDS and unit manager if not in care plan. At quarterly care conference, Social Services will address any behavior are entered into MDS and docume in Multidisciplinary care conference assessment. A progress note will accompleted regarding outcome of discussion with the IDT. Unit manages the nupdate care plan, if necessary. The plan of correction will be integent into the quality assurance programe evaluated for its effectiveness by Edesignee, who will conduct random weekly x3, then monthly x3 months auditing behavior meeting minutes follow up as necessary. The facility alleges that it will be in substantial compliance with the staindicated by January 4, 2017.	Inform Intered stigated olan ented or les to MA to then to sist with ention Social when Inotify all st that int these ends o be lager will by les and look or a audits is and for

Minnesota Department of Health

STATE FORM 0T1M11 If continuation sheet 8 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
		00678		B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER	G HOME	427 MAIN	DRESS, CITY, S STREET NO A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN ' MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From pa the behavior occurr of occurrences on a	ed on a shift, not	the number	2 560			
	August 2016 -refused peri cares	one shift					
	September: -Refused toileting o -Physically abusive						
	October: -Refused oral cares -Refused toileting o -Refused dressing o -Verbally abusive of -Physically abusive -Screaming, yelling	n four shifts on two shifts n two shifts on two shifts	on one shift				
	November: -Refused toileting of -Physically abusive -Refused oral cares -Screaming, yelling -Verbally abusive of -refused an unspec	on six shifts s on two shifts , excessive noise n one shift					
	On 11/30/16, at 8:0 administrator (TMA manage R85's behavorking with R85.)-A stated she kno	ew how to				
	On 11/30/16, at 8:1 (NA)-D stated R85 cares. NA-D also s manage R85's beha working with R85.	struck out at staff tated she knew h	and refused ow to				

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

-	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING:			
		00678		B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME		STREET NO A, MN 56464			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 9		2 560			
	On 11/30/16, at 11:: nurse (LPN)-A state tracked behavior ar the NA's would let h interventions would however, she did no would have to look the surveyor ask the as she did not have On 11/30/16, at 3:1 (RN)-B stated she of these behaviors rat had witnessed resis know about the oth behaviors were not behavior monitoring know R85 was havior	ed the nursing of there was ner know. LP be in R85's of know what them up. LP e NA's about additional in 4 p.m. registed in the them wher, knew Restance to eat the er behaviors ed there woug. RN-B confing these bel	g assistants as anything bad 'N-A stated care plan, t they were and N-A suggested t R85's behaviors, aformation. There of nurse R85 was having 85 wandered and ing, but did not . RN-B stated if all be an order for irmed she did not haviors and had				
	On 12/1/16, at 8:32 reviewed R85's rec they had identified the and not physical aboption. RN-B states social worker thought they would notify her on 12/1/16, at 8:40 documented by the facility social worker entered them on the the resident's care of the states.	a.m. RN-B sorded behave them as more use, but that dif the MDS the behaviors er. a.m. RN-D NA's were reand the soce MDS. This	stated she had riors with staff and e "aggression" t was not an nurse or the swere a problem stated behaviors eviewed by the cial worker				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00678	B. WING	<u>-</u>	12/	01/2016
	PROVIDER OR SUPPLIER	G HOME 427 MA	ADDRESS, CITY, I In Street No Iga, Mn 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	On 12/1/16, at 8:43 (DON) confirmed R assessment of her behavioral care platbehaviors. On 12/1/16, at 9;12 worker (SW) confir have been identified. The facility Behaviorand Monitoring policity and Monitoring policity and psychosocial nunderstand, preventistress or loss of a include, at a minimulational symptom intensity, duration, denvironment and provided the behavior and and specific and motargeted behaviors for effectiveness of SUGGESTED MET administrator or despolicies and provided development of coradministrator or designations.	a.m. the director of nursing as 5 did not have an behaviors nor was a n developed related to the a.m. via telephone, the soci med R85's behaviors should d. Total Assessment, Intervention cy (Med-Pass 2001, revised erventions would be part of an overall care apported physical, functional eeds, and strives to at or relieve the resident's abilities. The care plan would turn, a description of the ms including frequency, poutcomes, location, recipitating factors or and individualized interventior d/or psychosocial symptoms easurable goals for the and how the staff will monitor	s . e e			
	TIME PERIOD FOR	R CORRECTION: Twenty-one	ءِ ا			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	LE CONSTRUCTION	(X3) DATE COMP	
		00678	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
GREEN I	PINE ACRES NURSIN	G HOMF	N STREET NO SA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ige 11	2 560			
	(21) days.					
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/4/17
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observati review, the facility fa provided as directed resident (R50) observations	ent is not met as evidenced ion, interview and document ailed to ensure oral care was d by the care plan for 1 of 1 erved for morning cares who staff for assistance with oral		It is the policy of Green Pine Acres provide good oral hygiene for all re in order to prevent infection, irritat tooth decay, and also to moisten rembranes and prevent odor. Policy regarding oral cares was re and revised on 12/21/16. Care plan for R50 was updated to possibility of refusal and steps statake if this were to occur. Staff meetings to be held to discussion or all respectively.	esidents ion, mucous viewed reflect ff are to	
	R20 was diagnosed vascular dementia, disease. R50's care plan dat required total assist	eport dated 11/20/16, indicated with Alzheimer's disease, depression, and gastro-reflux ted 11/20/16, indicated R50 tance with dressing and ical assist of one staff with ora brush twice a day.		residents in the facility who refuse care and care plans to be updated if necessary. Education was provided to NA-F a NA-E on 12/21/16. NARs will be p education regarding the procedure updated policy for oral cares prior January 4, 2016. All staff will be educated of revised The revised policy will be implementand the plan of correction will be	oral d on this and rovided e and to d policy.	
	•	g assistant assignment report		integrated into the quality assuran program and evaluated for its effectiveness by the DON or design		

	IT OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00678		B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME		STREET NO A, MN 5646			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ıge 12		2 565			
	directed staff to physically assist R50 with oral cares using a toothbrush twice a day. On 11/30/16, at 7:25 a.m. R50 was observed in bed with night clothes on, awake, laying on his back touching and holding on to the privacy curtain.				who will perform randomized audi will be completed once weekly x4 monthly x3 months, and findings were brought to QA meeting. Education regarding oral hygiene and refusal cares will be discussed yearly with NAR sannual evaluation.	weeks, will be n l of oral n each	
	curtain.				The facility alleges that it will be in substantial compliance with the st indicated by January 4, 2017.		
	On 11/30/16, at 8:16 a.m. nursing assistants (NA)-E and NA-F were observed to enter R50's room and provide morning cares. The NA's were observed to wash and dress R50. At approximately 8:40 a.m. R50 was transferred to the wheel chair with a mechanical lift. NA-E removed R50's lower dental partial from a denture cup on the sink and attempted to put them in R50's mouth. R50 was not accepting and became slightly agitated. NA-F stated R50 had sometimes refused to wear the dentures. After the second failed attempt, NA-E put the dental partials back in the denture cup. NA-E stated R50 had no upper teeth and no upper denture but had some teeth on the bottom and that was why it was a partial plate. NA-E proceeded to shave R50 and wheeled the resident out of the room and to the dining room.						
	On 11/30/16, at 8:5 had not provided R R50's teeth should mouth should have the toothette's beforoom.	50 oral hygic have been be at least bee	ene and stated brushed or the en swabbed with				
	On 11/30/16 at 8:52 teeth were not brus						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00678	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From page 13		2 565			
	cleaned before or after she attempted to put the partial dentures in place.					
	(RN)-F verified R50 brush teeth two tim resident had a histo inform the RN so th	1 a.m. registered nurse b's care plan directed staff to es a day. RN-F added, if a bry of refusing the staff were to lat another plan could be put ated oral cares were important				
	noted it was the pol good oral hygiene f prevent infection, ir	giene Policy revised 1/19/01, icy of the facility to provide or all residents in order to ritation and tooth decay. Good done to moisten the mucous help prevent odor.				
	the care plan shall care based on the represcribed and long include the physicial treatment, diet, and describe the types of	nt Care Plans policy indicated be a personalized plan of daily nature of illness, treatment g and short term goals. It shall in's orders for medications, other therapy. It shall of care needed and how they plished, and how the plans needs.				
	director of nursing (review and revise p to ensuring the care resident is followed designee (s) could staff and develop a	THOD OF CORRECTION: The DON) or designee (s)could olicies and procedures related plan for each individual. The director of nursing or develop a system to educate monitoring system to ensure care as directed by the written				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00678	B. WING		2/01/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
GREEN I	PINE ACRES NURSIN	G HOME	STREET NO A, MN 5646		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From pa	ge 14	2 565		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830		1/4/17
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident			
	by: Based on observati review, the facility fa behavioral manage residents (R85) who Alzheimer's diagnos behavioral and emo			It is the policy of Green Pine Acres that comprehensive care plan which is individualized and meets the resident semedical, nursing, mental, and psychological needs. R85 s care plan was revised on 11/30/by RN unit manager and education was provided to this RN, who was involved, 11/30/16. Nursing and Social Services will be educated regarding this process and the	16 on
		eport dated 12/1/16, indicated e was R85's primary		role in the process of developing an individualized, comprehensive care plan	1

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STATE FORM 6899 0T1M11 If continuation sheet 15 of 32

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLE	
ANDILAN	OF COTTILECTION	IDENTIFICATION NOMBER.	A. BUILDING	:	OOWII EE	
			B. WING		10/01/0010	
		00678	b. WING		12/01	/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	IG HOME	I STREET NO			
GILLETT	INC ACTICO HOROIT	MENAHG	A, MN 5646	4		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
				DEFICIENCY)		
2 830	Continued From pa	age 15	2 830			
	admission diagnosi	is.		which includes behaviors (if neede	ed for	
				that resident).		
				Monthly behavior meetings, next r		
		nimum Data Set (MDS) dated		date 12/29/2016, will discuss all re		
		R85 exhibited physical		with behaviors based on behavior nurses notes. Social services wi		
		ns directed toward others g, pushing, scratching,		group regarding behaviors being e		
		others sexually) 4 to 6 days in		into MDS and these are to be inve		
		ent period, but less than daily.		by the RN unit manager and care		
		se from R85's admission MDS		revised if necessary.		
		ior was not exhibited. R85's		To assure behaviors will be docun		
		d R85 had severely impaired		appropriately the electronic behav		
	cognition.			charting for NARs will prompt NAF report all behaviors to cart nurse/		
				document. The cart nurse/TMA is		
	R85's care plan lac	ked identification of, and		document what is reported and as		
	subsequent goals a	and interventions for, refusal of		interventions if still requiring interv		
		e or physically abusive		or additional assistance if needed		
	behaviors towards	caregivers.		services is to review these notes w		
				gathering information for MDS and unit manager if not in care plan.	a fiolity	
	Review of R85's be	ehavior progress notes since		At quarterly care conference, Soci	al	
		the following refusals and		Services will address any behavio		
	behaviors directed	to care:		are entered into MDS and docume	ent these	
				in Multidisciplinary care conferenc		
		quently refused oral and peri		assessment. A progress note will completed regarding outcome of	also be	
		n cares, verbally and buld strike out, hitting staff and		discussion with the IDT. Unit man	ager will	
		Staff needs to leave and return		then update care plan, if necessar		
	again and try.			The plan of correction will be integ		
	-11/6/16: R85 was v	wandering, yelling and hitting		into the quality assurance progran	n and	
		cares. Res stated, "everyone is		evaluated for its effectiveness by I		
	always watching ev			designee, who will conduct randor		
		incontinent of urine staff ner to the bathroom, and		weekly x3, then monthly x3 month auditing behavior meeting minutes		
		185 was hitting staff.		follow up as necessary.	5 101	
	Sharigo noi biloi, il	acc mac maning stant.		The facility alleges that it will be in		
				substantial compliance with the st		
		ing assistant book located at		indicated by January 4, 2017.		
	the nursing station	revealed a blank page labeled				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00678	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	behavior document	ation notes.				
	revealed the followi	oint of Care documentation ng behaviors were recorded ts (documentation indicated if red on a shift, not the number a shift):				
	August 2016 -refused peri cares one shift					
	September: -Refused toileting of -Physically abusive					
	October: -Refused oral cares one shift -Refused toileting on four shifts -Refused dressing on two shifts -Verbally abusive on two shifts -Physically abusive on two shifts -Screaming, yelling, excessive noise on one shift					
	-Verbally abusive of	on six shifts s on two shifts , excessive noise on two shifts				
	walking down the h	9 p.m. R85 was observed allway, replied hello when her day was going pretty				
	On 11/29/16, at 4:2	2 p.m. R85 was observed				

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STATEMENT OF DEFICIENCIES (X1)

		R/SUPPLIER/CLIA CATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				A. BUILDING.			
		00678		B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME		STREET NC A, MN 56464			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa seated on a couch station quietly foldir p.m., R85 stood up hallway. On 11/29/16, at 5:3 the dining room, an	by the Birchyng a tissue ir and began v	h her hand. At 4:37 walking down the was observed in	2 830			
	on a couch by the E 5:44 p.m. R85 wand room.	Birchwood nu dered back i	ursing station. At nto the dining				
	On 11/30/16, at 7:52 a.m. R85 was observed seated on a couch near the Birchwood nurses station with a covered beverage cup and a napkin. At 8:19 a.m., R85 was observed walking in the hall holding her husband's hand.						
	On 11/30/16, at 8:0 administrator (TMA manage R85's behavorking with her.)-A stated sh	ne knew how to				
	On 11/30/16, at 8:1 (NA)-D stated she behaviors because her. NA-D stated she the point of care an station. NA-D stated and refuse cares.	knew how to of experience ne charted co d in a book a	manage R85's be working with certain behaviors in at the nurses				
	On 11/30/16, at 11:: nurse (LPN)-A state tracked behaviors a the NA's would let h interventions would	ed the nursing and if there wher know. LF	ng assistants vas anything bad, PN-A stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00678	B. WING		12/	01/2016
	PROVIDER OR SUPPLIER	G HOME 427 MAII	DDRESS, CITY, S'N STREET NO	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	however, she did no them up. LPN-A su NA's about R85's b additional information	ot know them without looking ggested the surveyor ask the ehaviors, as she did not have on. 4 p.m. registered nurse	2 830			
	behaviors listed in trecorded or by who recorded behaviors supposed the behaviors supposed the behaviors have entered by the not know R85 was she knew R85 wan R85's resistance to the other behaviors heard about these that which was an ongo information on residuely behaviors were not behavior monitoring know R85 was haviored.	did not know how resident he lookback report were m. RN-B stated cart nurses in a progress note and viors listed on the reports a NAs. RN-B stated she did having these behaviors rather dered and had also witnessed eating but did not know about. RN-B stated she had not behaviors in report either, ing way of gathering dents. RN-B stated if ed there would be an order for g and confirmed she did not ing these behaviors, if she had we investigated them.				
	entered resident be	7 p.m. NA-A stated she haviors on to the point of care tem and also informed the				
	behaviors on the po the nurse. NA-B sta	8 p.m. NA-B stated she enters bint of care system and tells ated they have had training on viors, but it has been a while.				
	entered resident be	9 p.m. NA-C stated she haviors on the point of care at the cart nurse. NA-C stated				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00678	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 5646	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	- Солинаса г голи ра	ge 19 d type a progress note as well.	2 830			
	reviewed R85's recomply identified them physical abuse, but the documentation and MDS nurse or the s	a.m. RN-B stated she had orded behaviors with staff and as more "aggression" and not that was not an option within system. RN-B stated if the ocial worker thought roblem they would notify her.				
	documented by the facility social worke	a.m. RN-D stated behaviors NA's were reviewed by the r and the social worker MDS which occurs prior to conference.				
	(DON) stated the N behaviors and repo stated while she did documentation side progress notes, it di as many nursing no by the NAs. The DO be happening and se behavior, it should a manager. The DON were also noted in treports during which decide if there was intervention. The DO have an assessment planned intervention.	a.m. the director of nursing As should document rt to the nurse. The DON In't compare the NA's by side with the nursing id appear as if there were not sites as behaviors documented ON confirmed that both should stated depending on the also be reported to the unit I stated resident behaviors he morning and afternoon in time a unit manager could a pattern and a need for ON confirmed R85 did not int of her behaviors nor care has for the recorded behaviors. It is facility social worker pulled d them as a part of the essments.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00678	B. WING		12/0	1/2016
	PROVIDER OR SUPPLIER	G HOME 427 MAIN	DRESS, CITY, S STREET NO A, MN 56464	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	On 12/1/16, at 9;12 social worker stated information from the assistant data) and nurse narratives) are information from the but there was not a The social worker serelated to refusing admitted to the faci discussed at R85's. Review of R85's menote revealed no not identification, assessinterventions, and the one care conferthis was not reflected R85's behaviors she discussed as that was admission, specificated in the facility Behavior.	a.m. via telephone, the facility dhe gathered behavior e look back reports (nursing the progress notes (licensed also gathered some e book at the nursing station, whole lot of information there. Stated R85 had behaviors that care which was why she was lity and these behaviors were care conference. Cultidisciplinary care conference often on behaviors: Sement, monitoring or the social services section was orker stated R85 has had just rence and he did not know why ded in the notes. He confirmed ould have been identified and was the main reason for her ally behaviors related to	2 830			
	and Monitoring police 2015), indicated the evaluate new or chain order to identify any modifiable factor. The policy further irrulaterventions would an overall care enviphysical, functional strives to understar resident's distress of	cy (Med-Pass 2001, revised e facility would thoroughly anging behavioral symptoms underlying causes and address ors that may have contributed. Indicated: d be individualized and part of ironment that supports and psychosocial needs, and ad, prevent or relieve the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00678	B. WING		12/0	1/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME 427 MAIN	DRESS, CITY, S STREET NO A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	description of the befrequency, intensity environment and presituations, targets a for the behavior and -Specific and meas behaviors and how effectiveness of the	ehavioral symptoms including duration, outcomes, location, recipitating factors or and individualized interventions dor psychosocial symptoms urable goals for the targeted the staff would monitor for	2 830			
	The director of nurs develop and implementated to behavioral management. The provide training for implementation and management. The assurance committed audits to ensure committed.	sing (DON) or designee, could nent policies and procedures al identification and DON or designee, could all nursing staff on d documentation of behavioral quality assessment and ee could perform random				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liviservices to maintain and personal and o	is unable to carry out ing receives the necessary good nutrition, grooming,	2 920			1/4/17

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	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
	00678	B. WING		12/0	1/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GREEN PINE ACRES NURSING HO)MF	STREET NO A, MN 56464			
(X1) 18	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
R50's Diagnosis Report R20 was diagnosed with vascular dementia and gas R50's annual Minimum I 11/16/16, indicated R50 impairment, was totally cactivities of daily living at assistance with persona care. The MDS also indicavities or broken teeth. R50's Dental Care Area 11/10/16, indicated R50 down at gum line toward missing teeth. The asses received total assistance	nterview and document sure oral care was ent (R50) observed for dependent on staff for e which was not provided olan. dated 11/20/16, indicated a Alzheimer's disease, gastro-reflux disease. Data Set (MDS) dated had severe memory dependent on staff for all and required full physical all hygiene including oral icated R50 had obvious Assessment dated had one tooth broken di back and several ssment noted R50 oral cares.	2 920	It is the policy of Green Pine Acres provide good oral hygiene for all rein order to prevent infection, irritati tooth decay, and also to moisten membranes and prevent odor. Policy regarding oral cares was reand revised on 12/21/16. Care plan for R50 was updated to possibility of refusal and steps statake if this were to occur. Staff meetings to be held to discus residents in the facility who refuse care and care plans to be updated if necessary. Education was provided to NA-F NA-E on 12/21/16. NARs will be peducation regarding the procedure updated policy for oral cares prior January 4, 2016. All staff will be educated of revised The revised policy will be implement and the plan of correction will be integrated into the quality assurant program and evaluated for its effectiveness by the DON or design who will perform randomized audit will be completed once weekly x4 monthly x3 months, and findings who brought to QA meeting. Education regarding oral hygiene and refusal cares will be discussed yearly with NAR sannual evaluation. The facility alleges that it will be in substantial compliance with the staindicated by January 4, 2017.	esidents on, nucous viewed reflect ff are to es other oral I on this and rovided e and to d policy. ented ce gnee, is which weeks, vill be n I of oral i each	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00070		B. WING		40/0	1 /001 0
		00678				12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STREET NO	STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME		A, MN 5646			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ıge 23		2 920			
	The current nursing assistant assignment report directed staff to physically assist R50 with oral cares using a toothbrush twice a day.						
	On 11/30/16, at 7:25 a.m. R50 was observed in bed, with night clothes on. R50 was awake, laying on his back touching and holding on to the privacy curtain.						
	On 11/30/16, at 8:16 a.m. nursing assistants (NA)-E and NA-F were observed to enter R50's room and provide morning cares. The NA's were observed to wash and dress R50 and at approximately 8:40 a.m. R50 was transferred to the wheelchair via a mechanical lift. NA-E removed R50's lower dental partial from a denture cup on the sink and attempted to put them in R50's mouth. R50 was not accepting and became slightly agitated. NA-F stated R50 had sometime refused to wear the dentures. After the second failed attempt, NA-E put the dental partials back in the denture cup. NA-E stated R50 had no upper teeth and no upper denture but had some teeth on the bottom and that was why it was a partial plate. NA-E proceeded to shave R50 then wheeled R50 to the dining room.						
	On 11/30/16, at 8:5 had not provided or R50's teeth should mouth should have the toothettes befor room.	ral hygiene fo have been b at least bee	or R50 and stated rushed or the n swabbed with				
	On 11/30/16 at 8:52 teeth were not brus						

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BUILDING.			
		00678	Е	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	(i H()ME		TREET NO MN 56464			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 24		2 920			
	cleaned before or after she attempted to put the partial dentures in place.		he				
	be wheeled out of the inside of R50's	0 a.m. R50 was observed he dining room after break mouth could not be visual ald not open the mouth.	fast.				
	(RN)-F verified R50 brush teeth two time residents had a hist staff needed to info	1 a.m. registered nurse 0's care plan directed staff es a day. RN-F added, if tory of refusing oral cares, rm the RN so that another place. RN-F stated oral call should be done.					
	The facility Oral Hygiene Policy revised 1/19/01, noted it was the policy of the facility to provide good oral hygiene for all residents in order to prevent infection, irritation and tooth decay. Good oral hygiene is also done to moisten the mucous membranes and to help prevent odor.		ood				
	The director of nurs could ensure that re carry out activities of necessary services grooming, and pers	THOD OF CORRECTION: sing (DON) and or designe esidents who are unable to of daily living receive the to maintain good nutrition and oral hygiene. An uld be developed to ensure	,				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-	one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		7. Bolebind.				
00678			B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GREEN	PINE ACRES NURSIN	G HOME	STREET NO A, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 25	21375			
21375	21375 MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain sanitary storage of personal resident oxygen equipment/tubing for 6 of 6 residents (R2, R90, R52, R42, R6, R25) observed to have nasal oxygen tubing lying on the floor or touching unclean surfaces without a barrier for protection from contamination. In addition, the facility failed to maintain a sanitary and cleanable surface for 1 of 1 resident (R20) observed to have a grab bar wrapped in foam and taped on with duct tape which rendered it uncleanable. Findings include: On 11/30/16, at 11:56 a.m. R2's nasal cannula (tubing device used to deliver oxygen through the nose) and oxygen tubing was observed unprotected and lying on the floor in the resident's room.		21375			1/4/17
				It is the policy of Green Pine Acres provide an Infection Prevention ar Control Program that provides as sanitary, and comfortable environs and to help prevent the developm transmission of disease and infect Hooks have been placed on all ox concentrators for staff to use to we tubing when not in use. Resident oplans have been updated on those residents who remove their own of tubing. Proper hygiene techniques explained to those residents and documented as well.	nd safe, ment ent and tion. tygen ind up care e xygen	
				All residents with oxygen will be a by RN unit managers prior to 1/4/care plans updated regarding resiability to remove nasal cannulas a education provided and document care plan and nursing notes. Foam was removed from R20 sea All resident rooms were checked.	17 and dent s and ted in grab bar.	
	On 11/30/16, at 11:50 a.m. R90's nasal cannula tubing was observed draped over the oxygen concentrator with the nasal cannula up against/touching the concentrator's electrical			12/21/16 and no uncleanable surf remain on any bed grab bars. If no protect arms from bumping grab bare to offer resident a pillow to be next to resident when in bed. Nurses and NARs will be educate	eeded to pars staff placed	

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		00678		B. WING		12/01	1/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GREEN I	PINE ACRES NURSIN	G HOME		STREET NO A, MN 5646			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 26		21375			
	cord. On 11/30/16, at 11:46 a.m. R52's oxygen tubing was observed draped over R52's grab bar on the bed with the nasal cannula lying directly on the floor touching the waste basket. On 12/1/16, at 8:36 a.m. R52's oxygen tubing and nasal cannula was observed lying directly on the floor. On 11/30/16, at 7:43 a.m. R42's oxygen tubing was observed draped over the oxygen concentrator with the nasal cannula hanging close to the floor. On 12/1/16, at 8:42 a.m. R42's nasal cannula tubing was observed draped over the unmade bed touching the bare mattress.				regarding uncleanable surfaces and proper storage of nasal cannulas. Housekeeping staff will be educated and will monitor for uncleanable surfaces using a checklist for each room. This will be done on an ongoing basis when cleaning rooms. They will report to the unit manger if any are noted. Oxygen Policy to be updated by 1/4/17 which will include proper storage of nasal cannulas and this policy will be educated to staff. Infection control policy will be updated to include elimination of padding grab bars and instead offering a pillow when in bed. Policy will eliminate unclean able surfaces This will also be included in the education for all staff. All staff will be educated of revised policies. The revised policies will be		
	On 12/1/16, 8:34 a. was observed drap concentrator with the back side of the compression. On 11/30/16, at 7:5 tubing was observed concentrator with the against a heating was and on 12/01/16, at cannula and tubing floor with no protection. On 12/1/16, 10:20 at (DON) completed at the concentrator with the against and tubing floor with no protection.	ed over the one nasal cannot nasal cannot nasal cannot be nasa	oxygen nula touching the ith no barrier for a nasal cannula er the oxygen nula resting up ne concentrator 125's nasal ed lying on the ing. ctor of nursing above residents'		implemented and the plan of corre will be integrated into the quality assurance program and evaluated effectiveness by monitoring rooms oxygen and grab bars infection co concerns during monthly infection meetings, with next scheduled me 12/28/16. DON or designee will aumonthly infection meeting minutes any information documented to as follow up has been completed and changes are made as necessary. The facility alleges that it will be in substantial compliance with the strindicated by January 4, 2017.	been completed and made as necessary. Iteed into the quality or the proposition of the p	
	rooms and verified laying on the floor a						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00678	B. WING		12/	01/2016
	PROVIDER OR SUPPLIER	G HOME 427 MAI	DDRESS, CITY, N STREET NO GA, MN 5646			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	with no covering or the tubing should be cannula could at lea concentrator. The nasal cannula's we sanitary manner but facility policy was. Grab Bars On 11/29/16, at 11:0 observed equipped were covered with which created an understand the facility was to have the facility was to have the facility was to have grab bars covered if the facility was to have grab bars were covered but did not know howay. The facility Oxygen oxygen would be avadministered by oxygen would and indicate the provided and indicate	protection. The DON stated e wound up so the nasal ast hang on the knobs of the DON stated the tubing and re not being stored in a at was not certain what the oscillation of the protection of		DEFICIENC	Y)	
	tubing were to be s	cate how the cannula's and tored.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00678		B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/0	
GREEN I	PINE ACRES NURSIN	G HOME	STREET NO A, MN 56464			
(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 CROSS-REFERENCED TO THE APPROPOSED TO THE APPROPOSED CORRECTION (CROSS)	D BE	(X5) COMPLETE DATE
21375	sanitization was not obtained. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related the appropriate storage of reusable resident care equipment and the use of uncleanable foam padding and provide staff education. The administrator, DON or designee could develop an auditing system in order to ensure compliance.		21375			
21565	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication assessment was completed for 1 of 1 resident (R42) observed to self administer a nebulizer treatment.		21565	It is the policy of Green Pine Acres assess residents for appropriatent self-administration of medications. Education was provided to the nur involved, on 11/30/16. RNs, LPNs, TMAs will be educated regarding to policy for self-administration of bot medications and nebulizers after self-incomplete policy regarding self-administration.	ess of se , and he th set up.	1/4/17

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	(X3) DATE SURVEY COMPLETED					
00678 B. WING 12/01/20	16					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
GREEN PINE ACRES NURSING HOME 427 MAIN STREET NORTHEAST MENAHGA, MN 56464						
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) MPLETE DATE					
R42's Admission Record, dated 2/3/16, indicated R42 was diagnosed with chronic obstructive pulmonary disease (COPD), hypertension and atrial fibrillation. R42's quarterly Minimum Data Set (MDS) dated 10/17/16, indicated R42 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing and toileting; limited assistance with walking in her room and in the corridor, and was independent with eating and personal hygiene. R42's order summary report, printed on 12/1/16, indicated an order for DuoNeb Solution 0.5-2.5 (3) MG/ML (patroropium-Albuterol) 1 vial inhale orally two times a day for COPD. On 11/30/16, at 8:45 a.m. R42 was observed alone in her room seated in her wheelchair. R42 stated she was going to do her nebulizer treatment at this time and proceeded to do so. R42 stated she does this treatment on her own. Review of R42's medical record lacked a self administration assessment (SAM), care plan or order for SAM of nebulizer treatment. On 11/30/16, at 12:15 p.m. licensed practical nurse (LPN)-B stated R42 was used to doing the nebulizer treatment on her own. LPN-B stated staff set up the medication administration record (MAR). LPN-B stated R42 was used to doing the nebulizer settler R42 was used						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00678	B. WING		12/	01/2016
	PROVIDER OR SUPPLIER PINE ACRES NURSIN	G HOME 427 MAI	DDRESS, CITY, S N STREET NO GA, MN 56464			
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21565	treatment on her ow home and she does stated she would co of medications and an assessment, orc R42 to do self admit treatment. After sea electronic record, L find a SAM assessing On 11/30/16, at 12:	wn from when she lived at so not like to have help. LPN-B consider this self administration she did not know if there was der or care plan in place for inistration of her nebulizer arching through R42's PN-B confirmed she could not ment for R42. 39 p.m. the director of nursing				
	their nebulizer treat assessed by a regis planned. The DON assessed for SAM	esident was to self-administer ment, their ability should be stered nurse and care confirmed R42 had not been ability and self administration not identified on R42's care we been.				
	residents had the ri medications if deter interdisciplinary tea re-assessed quarte	of Medications indicated ght to self-administer rmined safe to do so by the m. This was also to be orly, and residents were to signing their wish to self				
	director of nursing (develop, review, an procedures to ensu administer medicati					

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		00678	B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER	G HOME 427 MAIN	DDRESS, CITY, S N STREET NO BA, MN 5646		·	
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21565	or designee could to ensure ongoing of	develop a monitoring system	21565			

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