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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0T1M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00678

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245563**

2.STATE VENDOR OR MEDICAID NO.
(L2) **475240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN PINE ACRES NURSING HOME**
(L4) **427 MAIN STREET NORTHEAST**
(L5) **MENAHGA, MN** (L6) **56464**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/25/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 02/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/30/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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 Meath

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

MDH
Minnesota Department of Health

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 Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245563 Y1	A. Building B. Wing Y2	1/25/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0247	Correction	ID Prefix F0279	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(e)(2)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	01/04/2017	LSC	01/04/2017	LSC	01/04/2017
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	01/04/2017	LSC	01/04/2017	LSC	01/04/2017
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	02/17/2017	36536	01/25/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/1/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245563	A. Building 01 - MAIN BUILDING 01 B. Wing	1/4/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 12/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TA/mm	DATE 02/17/2017	SIGNATURE OF SURVEYOR 33562	DATE 01/07/2017
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/29/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

MDH
Minnesota Department of Health

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 / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00678 Y1	A. Building B. Wing Y2	1/25/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20430	Correction	ID Prefix 20560	Correction	ID Prefix 20565	Correction
Reg. # MN Rule 4658.0210 Subp. 1	Completed	Reg. # MN Rule 4658.0405 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 3	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 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0800 Subp. 1	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 4658.1325 Subp. 4	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TA/mm	02/17/2017	33562	01/25/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/1/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0T1M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00678

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245563**

2.STATE VENDOR OR MEDICAID NO.
(L2) **475240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN PINE ACRES NURSING HOME**
(L4) **427 MAIN STREET NORTHEAST**
(L5) **MENAHGA, MN** (L6) **56464**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/30/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	All Completion dates 1/4/2017	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This 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. Findings include: R42's Admission Record, dated 2/3/16, indicated R42 was diagnosed with chronic obstructive	F 176	It is the policy of Green Pine Acres to assess residents for appropriateness of self-administration of medications. Education was provided to the nurse involved, on 11/30/16. RNs, LPNs, and TMAs will be educated regarding the policy for self-administration of both medications and nebulizers after set up. Policy regarding self-administration of medications was revised into 2-sections.	12/23/16

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

Electronically Signed | 12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 176	Continued From page 1 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 (ipatroropium-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 did her nebulizer treatment on her own. LPN-B stated staff set up the medication on their morning rounds and documented that as administered on R42's medication administration record (MAR). LPN-B stated R42 was used to doing the nebulizer treatment on her own from when she lived at home and she does not like to have help. LPN-B	F 176	One which includes all medications and another which is specific for nebulizers after set up by RN/LPN/TMA. Education regarding this policy was completed to the RN unit managers. An updated assessment was made and is now being utilized by RN unit managers for anyone who is self-administering nebulizers after set up. This assessment is to be done prior to initiating self-administration and quarterly. Assessment done on R42, physician order obtained, consent signed by R42, and care plan updated. A list of residents who are able to self-administer their nebulizers after set up are kept in a binder on each medication cart for cart nurse review. This is to be updated by RN unit manager as appropriate and cart nurse to notify RN unit manager if there are additional residents they feel should be assessed and possibly added to the list. All staff will be educated of revised policy. The new policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will monitor compliance with the policy by auditing once weekly x4 weeks, monthly x3 months, and findings will be brought to QA meeting. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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F 176	Continued From page 2 stated she would consider this self administration of medications and she did not know if there was an assessment, order or care plan in place for R42 to do self administration of her nebulizer treatment. After searching through R42's electronic record, LPN-B confirmed she could not find a SAM assessment for R42. On 11/30/16, at 12:39 p.m. the director of nursing (DON) stated if a resident was to self-administer their nebulizer treatment, their ability should be assessed by a registered nurse and care planned. The DON confirmed R42 had not been assessed for SAM ability and self administration of medication was not identified on R42's care plan and should have been. The undated facility policy titled Self-Administration of Medications indicated residents had the right to self-administer medications if determined safe to do so by the interdisciplinary team. This was also to be re-assessed quarterly, and residents were to sign a statement confirming their wish to self administer medications.	F 176		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 247	It is the policy of Green Pine Acres to	12/23/16

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F 247	Continued From page 3 facility failed to provide 1 of 1 resident (R84) with appropriate room change notification. Findings include: On 11/28/16, at 6:13 p.m. R84 stated she had shared a room with her spouse up until 11/22/16, when he had passed away. R84 stated the facility's social worker (SW) had initially told R84 that she could have some time to adjust to the loss of her spouse prior to having to move into a different room. However, on 11/25/16, R84 stated the SW told her that she had to move right away, but the room she was moving into would be kept a private room for a while. R84 stated that did not happen, as she received a roommate on the same day R84 moved into the new room. R84 stated she felt like she hadn't been provided a proper notice to move nor had she been given time to adjust to the loss of her husband prior to moving. 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. 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	F 247	document a room change in the resident'□s medical record. Licensed Social Worker has documented room change and followed up with R84 and will document the status of her psychosocial well-being after the room change. New room change policy, effective 12/22/2016, will require the social services department or designee to facilitate resident room changes in accordance with the Resident Bill of Rights and to do follow up documentation as needed and to specifically address those residents who are in the grieving process and watch for any psychosocial effects of the room change. Facility Room Change Notification Form will be updated and used to document any resident room changes. Systemic change will be assured by requiring that the LSW or designee complete the facility room change notification form that includes date, time of notification of the resident and family regarding the room change as well as that this has been charted within the medical record. The notification form will be part of our ongoing system and will be routed to the administrator at the completion of the process. This form will serve as a method for ongoing auditing in real time. The administrator will be responsible for using this form to audit actual charting within the residents medical records. All staff will be educated of new policy. The new policy will be implemented and	

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F 247	Continued From page 4 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 different semi-private room on 11/25/16, and had received a new roommate on 11/25/16, the same day she had moved into her new room. The SW confirmed R84's move had been made due to the facility's need to accommodate a new admission. The SW stated following the death of her husband, R84 had asked him if she could have some time to adjust before she would have to be moved into a different room. The SW stated R84 was a "little upset" when he had given her a verbal notice on 11/25/16, that she had to be moved. The SW verified R84 had not been provided the Resident Rights Regarding Room Transfer notice prior to R84's room change. The SW confirmed if the facility had not been expecting the new admission, the facility would have allowed R84 to stay where she was a little longer which would have given her more time to grieve the loss of her spouse and adjusted to the pending room change. The SW verified R84's medical record lacked documentation regarding any discussions around R84's room change, when it had occurred, R84's reaction to the proposed room change or how R84 had acclimated to R84's new room and roommate. The SW confirmed either himself or the director of nursing (DON) were responsible for documenting R84's room change in the medical record and verified R84's medical record lacked documentation regarding any discussions around R84's room change, when it had occurred, R84's reaction to the move, or how R84 had acclimated to her new room and roommate.	F 247	the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the administrator during audits of resident records conducted upon identifying residents with a room change form. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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F 247	Continued From page 5	F 247		

On 11/30/16, at 3:07 p.m. the DON stated the SW was responsible for making sure the appropriate room change notice was provided to residents when a room change was requested or needed. The DON confirmed it was expected that anytime a resident was moved this would be documented in the resident's medical record. The DON verified R84 had been moved to a new room on 11/25/16, and R84's medical record lacked documentation regarding if R84 had been provided appropriate notice of her room change.

On 12/1/16, at 8:46 a.m. the administrator confirmed R84's medical record lacked documentation that proper notice had been provided to R84 prior to R84's room change on 11/25/16.

Transfer, Room to Room policy dated 10/12, indicated the resident and/or guardian must be consulted about the room transfer. The resident request would be given consideration in making the transfer. In addition, the following documentation would be recorded in the residents' medical record:

1. Date and time the room transfer occurred
2. The title of the individual who assisted with the transfer
3. All assessment data obtained during the move
4. How the resident tolerated the move
5. If the resident refused the move, the reason(s) why and the interventions taken

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F 247	Continued From page 6 6. The signature and title of the person recording the data. Residents' Rights Regarding Room Transfers form dated 5/6/09, indicated residents must be notified in writing, of a proposed room transfer and the justification of the room transfer no later than seven days before the transfer to another room within the facility.	F 247		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 279	It is the policy of Green Pine Acres that a	12/23/16

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F 279	Continued From page 7 facility failed to develop a behavioral management care plan for 1 of 1 resident (R85) who had displayed behaviors which were not identified on the care plan. Findings include: R85's Diagnosis Report dated 12/1/16, indicated Alzheimer's Disease was R85's primary admission diagnosis. R85's quarterly MDS dated 11/9/16, indicated R85 exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 4 to 6 days in the assessment period, but less than daily. This is an increase from R85's admission MDS in which this behavior was not exhibited. R85's MDS also indicated R85 had severely impaired cognition. Review of R85's care plan lacks identification of, and subsequent goals and interventions for, refusal of care and aggressive or physically abusive behaviors towards caregivers. Review of R85's behavior progress notes since admission revealed the following refusals and behaviors directed to care: -10/17/16: R85 frequently refused oral and peri cares, resistive with cares, verbally and physically. R85 would strike out, hitting staff and hollering at them. Staff needs to leave and return	F 279	comprehensive care plan which is individualized and meets the resident□s medical, nursing, mental, and psychological needs. R85□s care plan was revised on 11/30/16 by RN unit manager and education was provided to this RN, who was involved, on 11/30/16. Nursing and Social Services will be educated regarding this process and their role in the process of developing an individualized, comprehensive care plan which includes behaviors (if needed for that resident). Monthly behavior meetings, next meeting date 1/4/2017, will discuss all residents with behaviors based on behavior notes in nurses□ notes. Social services will inform group regarding behaviors being entered into MDS and these are to be investigated by the RN unit manager and care plan revised if necessary. To assure behaviors will be documented appropriately the electronic behavior charting for NARs will prompt NARs to report all behaviors to cart nurse/TMA to document. The cart nurse/TMA is then to document what is reported and assist with interventions if still requiring intervention or additional assistance if needed. Social services is to review these notes when gathering information for MDS and notify unit manager if not in care plan. At quarterly care conference, Social Services will address any behaviors that	

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F 279	Continued From page 8 again and try. -11/6/16: R85 was wandering, yelling and hitting staff, and refused cares. Res stated, "everyone is always watching everything I do." -11/9/16: R85 was incontinent of urine staff attempted to take her to the bathroom, and change her brief, R85 was hitting staff. Review of the nursing assistant book at the nursing station revealed a blank page labeled behavior documentation notes. Review of R85's Point of Care documentation revealed the following behaviors were recorded by nursing assistants (documentation indicated if the behavior occurred on a shift, not the number of occurrences on a shift): August 2016 -refused peri cares one shift September: -Refused toileting one shift -Physically abusive one shift 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 November: -Refused toileting on six shifts -Physically abusive on six shifts	F 279	are entered into MDS and document these in Multidisciplinary care conference assessment. A progress note will also be completed regarding outcome of discussion with the IDT. Unit manager will then update care plan, if necessary. The plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by social services who will review behavior documentation daily for one month and then weekly x 4 weeks and monthly ongoing at behavior meetings. Any changes in behaviors will be communicated with IDT. Effectiveness will also be evaluated by DON or designee, who will conduct random audits of care plans weekly x3, then monthly x3 months and auditing behavior meeting minutes with care plans for follow up as necessary and submitting reporting to administrator to maintain compliance. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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F 279	Continued From page 9 -Refused oral cares on two shifts -Screaming, yelling, excessive noise on two shifts -Verbally abusive on one shift -refused an unspecified care on one shift. On 11/30/16, at 8:00 a.m. trained medication administrator (TMA)-A stated she knew how to manage R85's behaviors because of experience working with R85. On 11/30/16, at 8:10 a.m. nursing assistant (NA)-D stated R85 struck out at staff and refused cares. NA-D also stated she knew how to manage R85's behaviors because of experience working with R85. On 11/30/16, at 11:26 a.m. licensed practical nurse (LPN)-A stated the nursing assistants tracked behavior and if there was anything bad the NA's would let her know. LPN-A stated interventions would be in R85's care plan, however, she did not know what they were and would have to look them up. LPN-A suggested the surveyor ask the NA's about R85's behaviors, as she did not have additional information. On 11/30/16, at 3:14 p.m. registered nurse (RN)-B stated she did not know R85 was having these behaviors rather, knew R85 wandered and had witnessed resistance to eating, but did not know about the other behaviors. RN-B 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	F 279		

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F 279	Continued From page 10	F 279		

behavior monitoring. RN-B confirmed she did not know R85 was having these behaviors and had she known, she would have investigated.

On 12/1/16, at 8:32 a.m. RN-B stated she had reviewed R85's recorded behaviors with staff and they had identified them as more "aggression" and not physical abuse, but that was not an option. RN-B stated if the MDS nurse or the social worker thought behaviors were a problem they would notify her.

On 12/1/16, at 8:40 a.m. RN-D stated behaviors documented by the NA's were reviewed by the facility social worker and the social worker entered them on the MDS. This occurs prior to the resident's care conference.

On 12/1/16, at 8:43 a.m. the director of nursing (DON) confirmed R85 did not have an assessment of her behaviors nor was a behavioral care plan developed related to the behaviors.

On 12/1/16, at 9;12 a.m. via telephone, the social worker (SW) confirmed R85's behaviors should have been identified.

The facility Behavioral Assessment, Intervention and Monitoring policy (Med-Pass 2001, revised 2015), indicated interventions would be individualized and part of an overall care environment that supported physical, functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. The care plan would include, at a minimum, a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or situations, targets and individualized interventions for the behavior and/or psychosocial symptoms and specific and measurable goals for the targeted behaviors and how the staff will monitor for effectiveness of the interventions.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral care was provided as directed by the care plan for 1 of 1 resident (R50) observed for morning cares who was dependent on staff for assistance with oral care. Findings include: R50's Diagnosis Report dated 11/20/16, indicated R20 was diagnosed with Alzheimer's disease, vascular dementia, depression, and gastro-reflux	F 282	It is the policy of Green Pine Acres to provide good oral hygiene for all residents in order to prevent infection, irritation, tooth decay, and also to moisten mucous membranes and prevent odor. Policy regarding oral cares was reviewed and revised on 12/21/16. 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	12/23/16

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F 282	Continued From page 12 disease. R50's care plan dated 11/20/16, indicated R50 required total assistance with dressing and grooming and physical assist of one staff with oral cares using a toothbrush twice a day. 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, 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. 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.	F 282	care and care plans to be updated on this if necessary. Education was provided to NA-F and NA-E on 12/21/16. NARs will be provided education regarding the procedure and updated policy for oral cares prior to January 4, 2016. All staff will be educated of revised policy. The revised policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the DON or designee, who will perform randomized observational audits which will be completed twice a week on different shifts x3 months. Observational audits will maintain compliance that the care is being provided. Audits and findings will be brought to QA meeting. Education regarding oral hygiene and refusal of oral cares will be discussed yearly with each NAR□s annual evaluation. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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F 282	Continued From page 13 On 11/30/16, at 8:50 a.m. NA-F confirmed she had not provided R50 oral hygiene and stated R50's teeth should have been brushed or the mouth should have at least been swabbed with the toothette's before R50 was taken to the dining room. On 11/30/16 at 8:52 a.m. NA-E confirmed R50's teeth were not brushed or the mouth was not cleaned before or after she attempted to put the partial dentures in place. On 12/1/16, at 10:11 a.m. registered nurse (RN)-F verified R50's care plan directed staff to brush teeth two times a day. RN-F added, if a resident had a history of refusing the staff were to inform the RN so that another plan could be put into place. RN-F stated oral cares were important and 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. An undated Resident Care Plans policy indicated the care plan shall be a personalized plan of daily care based on the nature of illness, treatment prescribed and long and short term goals. It shall include the physician's orders for medications, treatment, diet, and other therapy. It shall describe the types of care needed and how they	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/01/2016

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F 282	Continued From page 14 can be best accomplished, and how the plans meet the residents' needs.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a behavioral management program for 1 of 1 residents (R85) who had behavior symptoms, an Alzheimer's diagnoses and was reviewed for behavioral and emotional status. Findings include: R85's Diagnosis Report dated 12/1/16, indicated Alzheimer's Disease was R85's primary admission diagnosis. R85's quarterly Minimum Data Set (MDS) dated 11/9/16, indicated R85 exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 4 to 6 days in the MDS assessment period, but less than daily.	F 309	It is the policy of Green Pine Acres that a comprehensive care plan which is individualized and meets the resident□s medical, nursing, mental, and psychological needs. R85□s care plan was revised on 11/30/16 by RN unit manager and education was provided to this RN, who was involved, on 11/30/16. Nursing and Social Services will be educated regarding this process and their role in the process of developing an individualized, comprehensive care plan which includes behaviors (if needed for that resident). Monthly behavior meetings, next meeting date 1/4/2017, will discuss all residents with behaviors based on behavior notes in nurses□ notes. Social services will inform	12/23/16

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F 309	Continued From page 15 This was an increase from R85's admission MDS in which this behavior was not exhibited. R85's MDS also indicated R85 had severely impaired cognition. R85's care plan lacked identification of, and subsequent goals and interventions for, refusal of care and aggressive or physically abusive behaviors towards caregivers. Review of R85's behavior progress notes since admission revealed the following refusals and behaviors directed to care: -10/17/16: R85 frequently refused oral and peri cares, resistive with cares, verbally and physically. R85 would strike out, hitting staff and hollering at them. Staff needs to leave and return again and try. -11/6/16: R85 was wandering, yelling and hitting staff, and refused cares. Res stated, "everyone is always watching everything I do." -11/9/16: R85 was incontinent of urine staff attempted to take her to the bathroom, and change her brief, R85 was hitting staff. Review of the nursing assistant book located at the nursing station revealed a blank page labeled behavior documentation notes. Review of R85's Point of Care documentation revealed the following behaviors were recorded by nursing assistants (documentation indicated if the behavior occurred on a shift, not the number of occurrences on a shift):	F 309	group regarding behaviors being entered into MDS and these are to be investigated by the RN unit manager and care plan revised if necessary. To assure behaviors will be documented appropriately the electronic behavior charting for NARs will prompt NARs to report all behaviors to cart nurse/TMA to document. The cart nurse/TMA is then to document what is reported and assist with interventions if still requiring intervention or additional assistance if needed. Social services is to review these notes when gathering information for MDS and notify unit manager if not in care plan. At quarterly care conference, Social Services will address any behaviors that are entered into MDS and document these in Multidisciplinary care conference assessment. A progress note will also be completed regarding outcome of discussion with the IDT. Unit manager will then update care plan, if necessary. The plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by social services who will review behavior documentation daily for one month and then weekly x 4 weeks and monthly ongoing at behavior meetings. Any changes in behaviors will be communicated with IDT. Effectiveness will also be evaluated by DON or designee, who will conduct random audits of care plans weekly x3, then monthly x3 months and auditing behavior meeting minutes with care plans for follow up as necessary	

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	245563	A. BUILDING _____ B. WING _____	12/01/2016

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F 309	Continued From page 16 August 2016 -refused peri cares one shift September: -Refused toileting one shift -Physically abusive one shift 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 November: -Refused toileting on six shifts -Physically abusive on six shifts -Refused oral cares on two shifts -Screaming, yelling, excessive noise on two shifts -Verbally abusive on one shift -refused an unspecified care on one shift. On 11/29/16, at 3:49 p.m. R85 was observed walking down the hallway, replied hello when greeted and stated her day was going pretty good. On 11/29/16, at 4:22 p.m. R85 was observed seated on a couch by the Birchwood nursing station quietly folding a tissue in her hand. At 4:37 p.m., R85 stood up and began walking down the hallway. On 11/29/16, at 5:37 p.m. R85 was observed in	F 309	and reporting to administrator to maintain compliance. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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F 309	Continued From page 17	F 309		

the dining room, and then she left and went to sit on a couch by the Birchwood nursing station. At 5:44 p.m. R85 wandered back into the dining room.

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 8:00 a.m. trained medication administrator (TMA)-A stated she knew how to manage R85's behaviors because of experience working with her.

On 11/30/16, at 8:10 a.m. nursing assistant (NA)-D stated she knew how to manage R85's behaviors because of experience working with her. NA-D stated she charted certain behaviors in the point of care and in a book at the nurses station. NA-D stated R85 would strike out at staff and refuse cares.

On 11/30/16, at 11:26 a.m. licensed practical nurse (LPN)-A stated the nursing assistants tracked behaviors and if there was anything bad, the NA's would let her know. LPN-A stated interventions would be in R85's care plan however, she did not know them without looking them up. LPN-A suggested the surveyor ask the NA's about R85's behaviors, as she did not have additional information.

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F 309	Continued From page 18	F 309		

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.

On 11/30/16, at 3:28 p.m. NA-B stated she enters behaviors on the point of care system and tells the nurse. NA-B stated they have had training on how to record behaviors, but it has been a while.

On 11/30/16, at 3:29 p.m. NA-C stated she entered resident behaviors on the point of care system and informed the cart nurse. NA-C stated the cart nurse would type a progress note as well.

On 12/1/16, at 8:32 a.m. RN-B stated she had reviewed R85's recorded behaviors with staff and

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	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 19	F 309		

they identified them as more "aggression" and not physical abuse, but that was not an option within the documentation system. RN-B stated if the MDS nurse or the social worker thought behaviors were a problem they would notify her.

On 12/1/16, at 8:40 a.m. RN-D stated behaviors documented by the NA's were reviewed by the facility social worker and the social worker entered them in the MDS which occurs prior to the resident's care conference.

On 12/1/16, at 8:43 a.m. the director of nursing (DON) stated the NAs should document behaviors and report to the nurse. The DON stated while she didn't compare the NA's documentation side by side with the nursing progress notes, it did appear as if there were not as many nursing notes as behaviors documented by the NAs. The DON confirmed that both should be happening and stated depending on the behavior, it should also be reported to the unit manager. The DON stated resident behaviors were also noted in the morning and afternoon reports during which time a unit manager could decide if there was a pattern and a need for intervention. The DON confirmed R85 did not have an assessment of her behaviors nor care planned interventions for the recorded behaviors. The DON stated the facility social worker pulled the reports and used them as a part of the quarterly MDS assessments.

On 12/1/16, at 9;12 a.m. via telephone, the facility social worker stated he gathered behavior information from the look back reports (nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 20	F 309		

assistant data) and the progress notes (licensed nurse narratives) and also gathered some information from the book at the nursing station, but there was not a whole lot of information there. The social worker stated R85 had behaviors that related to refusing care which was why she was admitted to the facility and these behaviors were discussed at R85's care conference.

Review of R85's multidisciplinary care conference note revealed no notes on behaviors: identification, assessment, monitoring or interventions, and the social services section was blank. The social worker stated R85 has had just the one care conference and he did not know why this was not reflected in the notes. He confirmed R85's behaviors should have been identified and discussed as that was the main reason for her admission, specifically behaviors related to refusing care.

The facility Behavioral Assessment, Intervention and Monitoring policy (Med-Pass 2001, revised 2015), indicated the facility would thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed. The policy further indicated:
-Interventions would be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.
-The care plan would include, at a minimum, a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or

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	245563	A. BUILDING _____ B. WING _____	12/01/2016

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F 309	Continued From page 21 situations, targets and individualized interventions for the behavior and/or psychosocial symptoms -Specific and measurable goals for the targeted behaviors and how the staff would monitor for effectiveness of the interventions.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to ensure oral care was provided for 1 of 1 resident (R50) observed for morning cares who was dependent on staff for assistance with oral care which was not provided as directed by the care plan. Findings include: R50's Diagnosis Report dated 11/20/16, indicated R20 was diagnosed with Alzheimer's disease, vascular dementia and gastro-reflux disease. R50's annual Minimum Data Set (MDS) dated 11/16/16, indicated R50 had severe memory impairment, was totally dependent on staff for all activities of daily living and required full physical	F 312	It is the policy of Green Pine Acres to provide good oral hygiene for all residents in order to prevent infection, irritation, tooth decay, and also to moisten mucous membranes and prevent odor. Policy regarding oral cares was reviewed and revised on 12/21/16. 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 this if necessary. Education was provided to NA-F and NA-E on 12/21/16. NARs will be provided education regarding the procedure and	12/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 22 assistance with personal hygiene including oral care. The MDS also indicated R50 had obvious cavities or broken teeth. R50's Dental Care Area Assessment dated 11/10/16, indicated R50 had one tooth broken down at gum line toward back and several missing teeth. The assessment noted R50 received total assist for oral cares. R50's care plan dated 11/20/16, indicated R50 required total assistance with dressing and grooming and physical assist of one staff with oral cares using a toothbrush twice a day. 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	F 312	updated policy for oral cares prior to January 4, 2016. All staff will be educated of revised policy. The revised policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the DON or designee, who will perform randomized observational audits which will be completed twice a week on different shifts x3 months. Observational audits will maintain compliance that the care is being provided. Audits and findings will be brought to QA meeting. Education regarding oral hygiene and refusal of oral cares will be discussed yearly with each NAR□s annual evaluation. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 23	F 312		

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 8:50 a.m. NA-F confirmed she had not provided oral hygiene for R50 and stated R50's teeth should have been brushed or the mouth should have at least been swabbed with the toothettes before R50 was taken to the dining room.

On 11/30/16 at 8:52 a.m. NA-E confirmed R50's teeth were not brushed or the mouth was not cleaned before or after she attempted to put the partial dentures in place.

On 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.

On 12/1/16, at 10:11 a.m. registered nurse (RN)-F verified R50's care plan directed staff to brush teeth two times a day. RN-F added, if residents had a history of refusing oral cares, staff needed to inform the RN so that another plan could be put in place. RN-F stated oral cares were important and should be done.

The facility Oral Hygiene Policy revised 1/19/01,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 24 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.	F 312		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		12/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 25 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This 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. 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 cord.	F 441	It is the policy of Green Pine Acres to provide an Infection Prevention and Control Program that provides as safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Hooks have been placed on all oxygen concentrators for staff to use to wind up tubing when not in use. Resident care plans have been updated on those residents who remove their own oxygen tubing. Proper hygiene techniques explained to those residents and documented as well. All residents with oxygen will be assessed by RN unit managers prior to 1/4/17 and care plans updated regarding resident□s ability to remove nasal cannulas and education provided and documented in care plan and nursing notes. Foam was removed from R20□s grab bar. All resident rooms were checked on 12/21/16 and no uncleanable surfaces remain on any bed grab bars. If needed to protect arms from bumping grab bars staff are to offer resident a pillow to be placed next to resident when in bed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 26 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. On 12/1/16, 8:34 a.m. R6's nasal cannula tubing was observed draped over the oxygen concentrator with the nasal cannula touching the back side of the concentrator with no barrier for protection. On 11/30/16, at 7:50 a.m. R25's nasal cannula tubing was observed draped over the oxygen concentrator with the nasal cannula resting up against a heating vent behind the concentrator and on 12/01/16, at 8:34 a.m. R25's nasal cannula and tubing was observed lying on the floor with no protection or covering. On 12/1/16, 10:20 a.m. the director of nursing (DON) completed a tour of the above residents' rooms and verified the nasal cannula's were laying on the floor and touching unclean surfaces with no covering or protection. The DON stated	F 441	Nurses and NARs will be provided education 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 and educated to all staff by 1/4/17 which will include proper storage of nasal cannulas. 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 implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by monitoring rooms for grab bars and uncleanable surfaces during monthly infection meetings, with next scheduled meeting on 12/28/16. Walk through for checks of oxygen tubing will be done twice a week on different shifts to identify and maintain compliance. DON or designee will audit monthly infection meeting minutes and any information documented to assure follow up has been completed and changes are made as necessary.	

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	245563	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 27 the tubing should be wound up so the nasal cannula could at least hang on the knobs of the concentrator. The DON stated the tubing and nasal cannula's were not being stored in a sanitary manner but was not certain what the facility policy was. Grab Bars On 11/29/16, at 11:05 a.m. R20's bed was observed equipped with bilateral grab bars which were covered with grey foam and dark duct tape which created an uncleanable surface. On 12/1/16, at 10:45 a.m. registered nurse (RN)-F stated she was not aware any one had grab bars covered in foam. RN-F stated no one in the facility was to have foam and duct tape on their grab bars because there was no way to clean or sanitize the foam. RN-F verified R20's grab bars were covered with foam and duct tape but did not know how long they had been that way. The facility Oxygen Policy, dated 6/12, indicated oxygen would be available for residents and be administered by oxygen concentrator or tank while in building. An undated cleaning policy was provided and indicated Oxygen Cannula's were to be changed every two weeks and as needed. The policies did not indicate how the cannula's and tubing were to be stored. A grab bar policy related to cleaning and	F 441	The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

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F 441	Continued From page 28 sanitization was not obtained.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Green Pine Acres Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	EPOC	

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility has been inspected as one building, as of November 1, 2016 both buildings are considered as existing. Green Pine Acres Nursing Home was constructed in five different years. The original building is a 1-story building with partial basement build in 1964 and was determined to be of Type II(111) construction. In 1969 a 1-story building without basement was added to the west of the original building and was determined to be of Type II(111) construction. In 1996 the administration addition and connecting link was constructed to the southeast corner of the original build that is a 1-story building without basement that was determined to be of Type V(111) construction. In 1999 a 1-story building without basement addition was added to the northwest of the original building that was determined to be of II(111) construction. In 2004 a 1-story addition without basement was added to the original building and was determined to be of Type II(111) construction.	K 000		

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	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

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K 000	Continued From page 2 The entire facility is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in	K 353	It is the policy of Green Pine Acres to maintain automatic sprinkler systems in	12/23/16

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	245563	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2016**

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GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST** **MENAHGA, MN 56464**

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K 353	Continued From page 3 accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect 29 of 62 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 12:00 pm and 4:00 pm on 11-29-2016 observations and staff interview revealed 3 sprinkler heads were not replaced when the fluid in the frangible bulbs turned from red to yellow or clear. The locations are, one in the kitchen freezer, one in shower room 354A, and one in soiled utility room 473. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 353	reliable operating condition and to test periodically. The sprinkler heads in the kitchen freezer, shower room 354A, and soiled utility room 473, have an orange colored liquid bulb. After further investigation by the maintenance supervisor, it was determined that the orange liquid means that the sprinkler head has different heat sensitivity than the red colored liquid. The orange liquid bulb has a heat sensitive temperature of 135 degrees while the red is 155 degrees. Conversation with Summit, our fire alarm system company, verified the orange colored sprinkler head is adequate protection as long as the two colors are not located in the same room. A walk through check completed 12/21/2016 by the maintenance supervisor and administrator assured that the orange and red colored sprinkler head bulbs are separated by a fire door and are not located in the same room.	

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00678	A. BUILDING: _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 28, 29, 30 and December 1, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00678	A. BUILDING: _____ B. WING _____	12/01/2016

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2 000	Continued From page 2 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.	2 000		
2 430	MN Rule 4658.0210 Subp. 1 Room Assignments Subpart 1. Room assignments and furnishings. A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide 1 of 1 resident (R84) with appropriate room change notification. Findings include: On 11/28/16, at 6:13 p.m. R84 stated she had shared a room with her spouse up until 11/22/16, when he had passed away. R84 stated the facility's social worker (SW) had initially told R84 that she could have some time to adjust to the loss of her spouse prior to having to move into a different room. However, on 11/25/16, R84 stated the SW told her that she had to move right away, but the room she was moving into would be kept a private room for a while. R84 stated that	2 430	It is the policy of Green Pine Acres to document a room change in the resident□s medical record. Licensed Social Worker will document room change and follow up with R84 and document the status of her psychosocial well-being after the room change. New room change policy, effective 12/22/2016, will require the social services department or designee to facilitate resident room changes in accordance with the Resident Bill of Rights and to do follow up documentation as needed and to specifically address those residents who are in the grieving process and watch for any psychosocial effects of the room change. Facility Room Change Notification Form will be updated and used to	1/4/17

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2 430	Continued From page 3 did not happen, as she received a roommate on the same day R84 moved into the new room. R84 stated she felt like she hadn't been provided a proper notice to move nor had she been given time to adjust to the loss of her husband prior to moving. 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. 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 different semi-private room on 11/25/16, and had received a new roommate on 11/25/16, the same day she had moved into her new room. The SW confirmed R84's move had been made due to the facility's need to accommodate a new admission. The SW stated following the death of her husband, R84 had asked him if she could have some time to adjust before she would have to be moved into a different room. The SW stated R84 was a "little upset" when he had given her a verbal notice on 11/25/16, that she had to be moved. The SW verified R84 had not been	2 430	document any resident room changes. Systemic change will be assured by requiring that the LSW or designee complete the facility room change notification form that includes date, time of notification of the resident and family regarding the room change as well as that this has been charted within the medical record. The notification form will be part of our ongoing system and will be routed to the administrator at the completion of the process. This form will serve as a method for ongoing auditing in real time. The administrator will be responsible for using this form to audit actual charting within the residents medical records. All staff will be educated of new policy. The new policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the administrator during audits of resident records conducted upon identifying residents with a room change form. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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2 430	Continued From page 4 provided the Resident Rights Regarding Room Transfer notice prior to R84's room change. The SW confirmed if the facility had not been expecting the new admission, the facility would have allowed R84 to stay where she was a little longer which would have given her more time to grieve the loss of her spouse and adjusted to the pending room change. The SW verified R84's medical record lacked documentation regarding any discussions around R84's room change, when it had occurred, R84's reaction to the proposed room change or how R84 had acclimated to R84's new room and roommate. The SW confirmed either himself or the director of nursing (DON) were responsible for documenting R84's room change in the medical record and verified R84's medical record lacked documentation regarding any discussions around R84's room change, when it had occurred, R84's reaction to the move, or how R84 had acclimated to her new room and roommate. On 11/30/16, at 3:07 p.m. the DON stated the SW was responsible for making sure the appropriate room change notice was provided to residents when a room change was requested or needed. The DON confirmed it was expected that anytime a resident was moved this would be documented in the resident's medical record. The DON verified R84 had been moved to a new room on 11/25/16, and R84's medical record lacked documentation regarding if R84 had been provided appropriate notice of her room change. On 12/1/16, at 8:46 a.m. the administrator confirmed R84's medical record lacked documentation that proper notice had been provided to R84 prior to R84's room change on	2 430		

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2 430	Continued From page 5 11/25/16. Transfer, Room to Room policy dated 10/12, indicated the resident and/or guardian must be consulted about the room transfer. The resident request would be given consideration in making the transfer. In addition, the following documentation would be recorded in the residents' medical record: 1. Date and time the room transfer occurred 2. The title of the individual who assisted with the transfer 3. All assessment data obtained during the move 4. How the resident tolerated the move 5. If the resident refused the move, the reason(s) why and the interventions taken 6. The signature and title of the person recording the data. Residents' Rights Regarding Room Transfers form dated 5/6/09, indicated residents must be notified in writing, of a proposed room transfer and the justification of the room transfer no later than seven days before the transfer to another room within the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the social worker/designee to update policies and procedures for when to notify the resident(s) of room/roommate changes, and then could educate staff. The DON or designee could also perform audits of resident records to determine if	2 430		

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2 430	Continued From page 6 the resident(s) had been notified as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 430		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a behavioral management care plan for 1 of 1 resident (R85) who had displayed behaviors which were not identified on the care plan. Findings include: R85's Diagnosis Report dated 12/1/16, indicated Alzheimer's Disease was R85's primary admission diagnosis. R85's quarterly MDS dated 11/9/16, indicated R85 exhibited physical behavioral symptoms	2 560	It is the policy of Green Pine Acres that a comprehensive care plan which is individualized and meets the resident□s medical, nursing, mental, and psychological needs. R85□s care plan was revised on 11/30/16 by RN unit manager and education was provided to this RN, who was involved, on 11/30/16. Nursing and Social Services will be educated regarding this process and their role in the process of developing an individualized, comprehensive care plan which includes behaviors (if needed for that resident). Monthly behavior meetings, next meeting date 12/29/2016, will discuss all residents	1/4/17

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2 560	Continued From page 7 directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 4 to 6 days in the assessment period, but less than daily. This is an increase from R85's admission MDS in which this behavior was not exhibited. R85's MDS also indicated R85 had severely impaired cognition. Review of R85's care plan lacks identification of, and subsequent goals and interventions for, refusal of care and aggressive or physically abusive behaviors towards caregivers. Review of R85's behavior progress notes since admission revealed the following refusals and behaviors directed to care: -10/17/16: R85 frequently refused oral and peri cares, resistive with cares, verbally and physically. R85 would strike out, hitting staff and hollering at them. Staff needs to leave and return again and try. -11/6/16: R85 was wandering, yelling and hitting staff, and refused cares. Res stated, "everyone is always watching everything I do." -11/9/16: R85 was incontinent of urine staff attempted to take her to the bathroom, and change her brief, R85 was hitting staff. Review of the nursing assistant book at the nursing station revealed a blank page labeled behavior documentation notes. Review of R85's Point of Care documentation revealed the following behaviors were recorded by nursing assistants (documentation indicated if	2 560	with behaviors based on behavior notes in nurses notes. Social services will inform group regarding behaviors being entered into MDS and these are to be investigated by the RN unit manager and care plan revised if necessary. To assure behaviors will be documented appropriately the electronic behavior charting for NARs will prompt NARs to report all behaviors to cart nurse/TMA to document. The cart nurse/TMA is then to document what is reported and assist with interventions if still requiring intervention or additional assistance if needed. Social services is to review these notes when gathering information for MDS and notify unit manager if not in care plan. At quarterly care conference, Social Services will address any behaviors that are entered into MDS and document these in Multidisciplinary care conference assessment. A progress note will also be completed regarding outcome of discussion with the IDT. Unit manager will then update care plan, if necessary. The plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will conduct random audits weekly x3, then monthly x3 months and auditing behavior meeting minutes for follow up as necessary. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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2 560	Continued From page 8 the behavior occurred on a shift, not the number of occurrences on a shift): August 2016 -refused peri cares one shift September: -Refused toileting one shift -Physically abusive one shift 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 November: -Refused toileting on six shifts -Physically abusive on six shifts -Refused oral cares on two shifts -Screaming, yelling, excessive noise on two shifts -Verbally abusive on one shift -refused an unspecified care on one shift. On 11/30/16, at 8:00 a.m. trained medication administrator (TMA)-A stated she knew how to manage R85's behaviors because of experience working with R85. On 11/30/16, at 8:10 a.m. nursing assistant (NA)-D stated R85 struck out at staff and refused cares. NA-D also stated she knew how to manage R85's behaviors because of experience working with R85.	2 560		

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2 560	Continued From page 9 On 11/30/16, at 11:26 a.m. licensed practical nurse (LPN)-A stated the nursing assistants tracked behavior and if there was anything bad the NA's would let her know. LPN-A stated interventions would be in R85's care plan, however, she did not know what they were and would have to look them up. LPN-A suggested the surveyor ask the NA's about R85's behaviors, as she did not have additional information. On 11/30/16, at 3:14 p.m. registered nurse (RN)-B stated she did not know R85 was having these behaviors rather, knew R85 wandered and had witnessed resistance to eating, but did not know about the other behaviors. RN-B stated if behaviors were noted there would be an order for behavior monitoring. RN-B confirmed she did not know R85 was having these behaviors and had she known, she would have investigated. On 12/1/16, at 8:32 a.m. RN-B stated she had reviewed R85's recorded behaviors with staff and they had identified them as more "aggression" and not physical abuse, but that was not an option. RN-B stated if the MDS nurse or the social worker thought behaviors were a problem they would notify her. On 12/1/16, at 8:40 a.m. RN-D stated behaviors documented by the NA's were reviewed by the facility social worker and the social worker entered them on the MDS. This occurs prior to the resident's care conference.	2 560		

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2 560	Continued From page 10 On 12/1/16, at 8:43 a.m. the director of nursing (DON) confirmed R85 did not have an assessment of her behaviors nor was a behavioral care plan developed related to the behaviors. On 12/1/16, at 9;12 a.m. via telephone, the social worker (SW) confirmed R85's behaviors should have been identified. The facility Behavioral Assessment, Intervention and Monitoring policy (Med-Pass 2001, revised 2015), indicated interventions would be individualized and part of an overall care environment that supported physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. The care plan would include, at a minimum, a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or situations, targets and individualized interventions for the behavior and/or psychosocial symptoms and specific and measurable goals for the targeted behaviors and how the staff will monitor for effectiveness of the interventions. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the development of comprehensive care plans. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 560		

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2 560	Continued From page 11 (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral care was provided as directed by the care plan for 1 of 1 resident (R50) observed for morning cares who was dependent on staff for assistance with oral care. Findings include: R50's Diagnosis Report dated 11/20/16, indicated R20 was diagnosed with Alzheimer's disease, vascular dementia, depression, and gastro-reflux disease. R50's care plan dated 11/20/16, indicated R50 required total assistance with dressing and grooming and physical assist of one staff with oral cares using a toothbrush twice a day. The current nursing assistant assignment report	2 565	It is the policy of Green Pine Acres to provide good oral hygiene for all residents in order to prevent infection, irritation, tooth decay, and also to moisten mucous membranes and prevent odor. Policy regarding oral cares was reviewed and revised on 12/21/16. 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 this if necessary. Education was provided to NA-F and NA-E on 12/21/16. NARs will be provided education regarding the procedure and updated policy for oral cares prior to January 4, 2016. All staff will be educated of revised policy. The revised policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the DON or designee,	1/4/17

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2 565	Continued From page 12 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. 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 8:50 a.m. NA-F confirmed she had not provided R50 oral hygiene and stated R50's teeth should have been brushed or the mouth should have at least been swabbed with the toothette's before R50 was taken to the dining room. On 11/30/16 at 8:52 a.m. NA-E confirmed R50's teeth were not brushed or the mouth was not	2 565	who will perform randomized audits which will be completed once weekly x4 weeks, monthly x3 months, and findings will be brought to QA meeting. Education regarding oral hygiene and refusal of oral cares will be discussed yearly with each NAR□s annual evaluation. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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2 565	Continued From page 13 cleaned before or after she attempted to put the partial dentures in place. On 12/1/16, at 10:11 a.m. registered nurse (RN)-F verified R50's care plan directed staff to brush teeth two times a day. RN-F added, if a resident had a history of refusing the staff were to inform the RN so that another plan could be put into place. RN-F stated oral cares were important and 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. An undated Resident Care Plans policy indicated the care plan shall be a personalized plan of daily care based on the nature of illness, treatment prescribed and long and short term goals. It shall include the physician's orders for medications, treatment, diet, and other therapy. It shall describe the types of care needed and how they can be best accomplished, and how the plans meet the residents' needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s) could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written	2 565		

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	00678	A. BUILDING: _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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2 565	Continued From page 14 plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a behavioral management program for 1 of 1 residents (R85) who had behavior symptoms, an Alzheimer's diagnoses and was reviewed for behavioral and emotional status. Findings include: R85's Diagnosis Report dated 12/1/16, indicated Alzheimer's Disease was R85's primary	2 830	It is the policy of Green Pine Acres that a comprehensive care plan which is individualized and meets the resident□s medical, nursing, mental, and psychological needs. R85□s care plan was revised on 11/30/16 by RN unit manager and education was provided to this RN, who was involved, on 11/30/16. Nursing and Social Services will be educated regarding this process and their role in the process of developing an individualized, comprehensive care plan	1/4/17

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2 830	Continued From page 15 admission diagnosis. R85's quarterly Minimum Data Set (MDS) dated 11/9/16, indicated R85 exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 4 to 6 days in the MDS assessment period, but less than daily. This was an increase from R85's admission MDS in which this behavior was not exhibited. R85's MDS also indicated R85 had severely impaired cognition. R85's care plan lacked identification of, and subsequent goals and interventions for, refusal of care and aggressive or physically abusive behaviors towards caregivers. Review of R85's behavior progress notes since admission revealed the following refusals and behaviors directed to care: -10/17/16: R85 frequently refused oral and peri cares, resistive with cares, verbally and physically. R85 would strike out, hitting staff and hollering at them. Staff needs to leave and return again and try. -11/6/16: R85 was wandering, yelling and hitting staff, and refused cares. Res stated, "everyone is always watching everything I do." -11/9/16: R85 was incontinent of urine staff attempted to take her to the bathroom, and change her brief, R85 was hitting staff. Review of the nursing assistant book located at the nursing station revealed a blank page labeled	2 830	which includes behaviors (if needed for that resident). Monthly behavior meetings, next meeting date 12/29/2016, will discuss all residents with behaviors based on behavior notes in nurses notes. Social services will inform group regarding behaviors being entered into MDS and these are to be investigated by the RN unit manager and care plan revised if necessary. To assure behaviors will be documented appropriately the electronic behavior charting for NARs will prompt NARs to report all behaviors to cart nurse/TMA to document. The cart nurse/TMA is then to document what is reported and assist with interventions if still requiring intervention or additional assistance if needed. Social services is to review these notes when gathering information for MDS and notify unit manager if not in care plan. At quarterly care conference, Social Services will address any behaviors that are entered into MDS and document these in Multidisciplinary care conference assessment. A progress note will also be completed regarding outcome of discussion with the IDT. Unit manager will then update care plan, if necessary. The plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will conduct random audits weekly x3, then monthly x3 months and auditing behavior meeting minutes for follow up as necessary. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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2 830	Continued From page 16 behavior documentation notes. Review of R85's Point of Care documentation revealed the following behaviors were recorded by nursing assistants (documentation indicated if the behavior occurred on a shift, not the number of occurrences on a shift): August 2016 -refused peri cares one shift September: -Refused toileting one shift -Physically abusive one shift 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 November: -Refused toileting on six shifts -Physically abusive on six shifts -Refused oral cares on two shifts -Screaming, yelling, excessive noise on two shifts -Verbally abusive on one shift -refused an unspecified care on one shift. On 11/29/16, at 3:49 p.m. R85 was observed walking down the hallway, replied hello when greeted and stated her day was going pretty good. On 11/29/16, at 4:22 p.m. R85 was observed	2 830		

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2 830	Continued From page 17 seated on a couch by the Birchwood nursing station quietly folding a tissue in her hand. At 4:37 p.m., R85 stood up and began walking down the hallway. On 11/29/16, at 5:37 p.m. R85 was observed in the dining room, and then she left and went to sit on a couch by the Birchwood nursing station. At 5:44 p.m. R85 wandered back into the dining room. 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 8:00 a.m. trained medication administrator (TMA)-A stated she knew how to manage R85's behaviors because of experience working with her. On 11/30/16, at 8:10 a.m. nursing assistant (NA)-D stated she knew how to manage R85's behaviors because of experience working with her. NA-D stated she charted certain behaviors in the point of care and in a book at the nurses station. NA-D stated R85 would strike out at staff and refuse cares. On 11/30/16, at 11:26 a.m. licensed practical nurse (LPN)-A stated the nursing assistants tracked behaviors and if there was anything bad, the NA's would let her know. LPN-A stated interventions would be in R85's care plan	2 830		

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2 830	Continued From page 18 however, she did not know them without looking them up. LPN-A suggested the surveyor ask the NA's about R85's behaviors, as she did not have additional information. 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. On 11/30/16, at 3:28 p.m. NA-B stated she enters behaviors on the point of care system and tells the nurse. NA-B stated they have had training on how to record behaviors, but it has been a while. On 11/30/16, at 3:29 p.m. NA-C stated she entered resident behaviors on the point of care system and informed the cart nurse. NA-C stated	2 830		

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2 830	Continued From page 19 the cart nurse would type a progress note as well. On 12/1/16, at 8:32 a.m. RN-B stated she had reviewed R85's recorded behaviors with staff and they identified them as more "aggression" and not physical abuse, but that was not an option within the documentation system. RN-B stated if the MDS nurse or the social worker thought behaviors were a problem they would notify her. On 12/1/16, at 8:40 a.m. RN-D stated behaviors documented by the NA's were reviewed by the facility social worker and the social worker entered them in the MDS which occurs prior to the resident's care conference. On 12/1/16, at 8:43 a.m. the director of nursing (DON) stated the NAs should document behaviors and report to the nurse. The DON stated while she didn't compare the NA's documentation side by side with the nursing progress notes, it did appear as if there were not as many nursing notes as behaviors documented by the NAs. The DON confirmed that both should be happening and stated depending on the behavior, it should also be reported to the unit manager. The DON stated resident behaviors were also noted in the morning and afternoon reports during which time a unit manager could decide if there was a pattern and a need for intervention. The DON confirmed R85 did not have an assessment of her behaviors nor care planned interventions for the recorded behaviors. The DON stated the facility social worker pulled the reports and used them as a part of the quarterly MDS assessments.	2 830		

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2 830	Continued From page 20 On 12/1/16, at 9;12 a.m. via telephone, the facility social worker stated he gathered behavior information from the look back reports (nursing assistant data) and the progress notes (licensed nurse narratives) and also gathered some information from the book at the nursing station, but there was not a whole lot of information there. The social worker stated R85 had behaviors that related to refusing care which was why she was admitted to the facility and these behaviors were discussed at R85's care conference. Review of R85's multidisciplinary care conference note revealed no notes on behaviors: identification, assessment, monitoring or interventions, and the social services section was blank. The social worker stated R85 has had just the one care conference and he did not know why this was not reflected in the notes. He confirmed R85's behaviors should have been identified and discussed as that was the main reason for her admission, specifically behaviors related to refusing care. The facility Behavioral Assessment, Intervention and Monitoring policy (Med-Pass 2001, revised 2015), indicated the facility would thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed. The policy further indicated: -Interventions would be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. -The care plan would include, at a minimum, a	2 830		

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2 830	Continued From page 21 description of the behavioral symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or situations, targets and individualized interventions for the behavior and/or psychosocial symptoms -Specific and measurable goals for the targeted behaviors and how the staff would monitor for effectiveness of the interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to behavioral identification and management. The DON or designee, could provide training for all nursing staff on implementation and documentation of behavioral management. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		1/4/17

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2 920	Continued From page 22 by: Based on observation, interview and document review, the facility to ensure oral care was provided for 1 of 1 resident (R50) observed for morning cares who was dependent on staff for assistance with oral care which was not provided as directed by the care plan. Findings include: R50's Diagnosis Report dated 11/20/16, indicated R20 was diagnosed with Alzheimer's disease, vascular dementia and gastro-reflux disease. R50's annual Minimum Data Set (MDS) dated 11/16/16, indicated R50 had severe memory impairment, was totally dependent on staff for all activities of daily living and required full physical assistance with personal hygiene including oral care. The MDS also indicated R50 had obvious cavities or broken teeth. R50's Dental Care Area Assessment dated 11/10/16, indicated R50 had one tooth broken down at gum line toward back and several missing teeth. The assessment noted R50 received total assist for oral cares. R50's care plan dated 11/20/16, indicated R50 required total assistance with dressing and grooming and physical assist of one staff with oral cares using a toothbrush twice a day.	2 920	It is the policy of Green Pine Acres to provide good oral hygiene for all residents in order to prevent infection, irritation, tooth decay, and also to moisten mucous membranes and prevent odor. Policy regarding oral cares was reviewed and revised on 12/21/16. 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 this if necessary. Education was provided to NA-F and NA-E on 12/21/16. NARs will be provided education regarding the procedure and updated policy for oral cares prior to January 4, 2016. All staff will be educated of revised policy. The revised policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by the DON or designee, who will perform randomized audits which will be completed once weekly x4 weeks, monthly x3 months, and findings will be brought to QA meeting. Education regarding oral hygiene and refusal of oral cares will be discussed yearly with each NAR□s annual evaluation. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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2 920	Continued From page 23 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 8:50 a.m. NA-F confirmed she had not provided oral hygiene for R50 and stated R50's teeth should have been brushed or the mouth should have at least been swabbed with the toothettes before R50 was taken to the dining room. On 11/30/16 at 8:52 a.m. NA-E confirmed R50's teeth were not brushed or the mouth was not	2 920		

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2 920	Continued From page 24 cleaned before or after she attempted to put the partial dentures in place. On 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. On 12/1/16, at 10:11 a.m. registered nurse (RN)-F verified R50's care plan directed staff to brush teeth two times a day. RN-F added, if residents had a history of refusing oral cares, staff needed to inform the RN so that another plan could be put in place. RN-F stated oral cares were important and 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. An auditing system could be developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty- one (21) days.	2 920		

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21375	Continued From page 25	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. 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	21375	It is the policy of Green Pine Acres to provide an Infection Prevention and Control Program that provides as safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Hooks have been placed on all oxygen concentrators for staff to use to wind up tubing when not in use. Resident care plans have been updated on those residents who remove their own oxygen tubing. Proper hygiene techniques explained to those residents and documented as well. All residents with oxygen will be assessed by RN unit managers prior to 1/4/17 and care plans updated regarding resident□s ability to remove nasal cannulas and education provided and documented in care plan and nursing notes. Foam was removed from R20□s grab bar. All resident rooms were checked on 12/21/16 and no uncleanable surfaces remain on any bed grab bars. If needed to protect arms from bumping grab bars staff are to offer resident a pillow to be placed next to resident when in bed. Nurses and NARs will be educated	1/4/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 26 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. On 12/1/16, 8:34 a.m. R6's nasal cannula tubing was observed draped over the oxygen concentrator with the nasal cannula touching the back side of the concentrator with no barrier for protection. On 11/30/16, at 7:50 a.m. R25's nasal cannula tubing was observed draped over the oxygen concentrator with the nasal cannula resting up against a heating vent behind the concentrator and on 12/01/16, at 8:34 a.m. R25's nasal cannula and tubing was observed lying on the floor with no protection or covering. On 12/1/16, 10:20 a.m. the director of nursing (DON) completed a tour of the above residents' rooms and verified the nasal cannula's were laying on the floor and touching unclean surfaces	21375	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 implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by monitoring rooms for oxygen and grab bars infection control concerns during monthly infection meetings, with next scheduled meeting on 12/28/16. DON or designee will audit monthly infection meeting minutes and any information documented to assure follow up has been completed and changes are made as necessary. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00678	A. BUILDING: _____ B. WING _____	12/01/2016

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21375	Continued From page 27 with no covering or protection. The DON stated the tubing should be wound up so the nasal cannula could at least hang on the knobs of the concentrator. The DON stated the tubing and nasal cannula's were not being stored in a sanitary manner but was not certain what the facility policy was. Grab Bars On 11/29/16, at 11:05 a.m. R20's bed was observed equipped with bilateral grab bars which were covered with grey foam and dark duct tape which created an uncleanable surface. On 12/1/16, at 10:45 a.m. registered nurse (RN)-F stated she was not aware any one had grab bars covered in foam. RN-F stated no one in the facility was to have foam and duct tape on their grab bars because there was no way to clean or sanitize the foam. RN-F verified R20's grab bars were covered with foam and duct tape but did not know how long they had been that way. The facility Oxygen Policy, dated 6/12, indicated oxygen would be available for residents and be administered by oxygen concentrator or tank while in building. An undated cleaning policy was provided and indicated Oxygen Cannula's were to be changed every two weeks and as needed. The policies did not indicate how the cannula's and tubing were to be stored. A grab bar policy related to cleaning and	21375		

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21375	Continued From page 28 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21565	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. Findings include:	21565	It is the policy of Green Pine Acres to assess residents for appropriateness of self-administration of medications. Education was provided to the nurse involved, on 11/30/16. RNs, LPNs, and TMAs will be educated regarding the policy for self-administration of both medications and nebulizers after set up. Policy regarding self-administration of	1/4/17

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21565	Continued From page 29 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 (ipatroropium-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 did her nebulizer treatment on her own. LPN-B stated staff set up the medication on their morning rounds and documented that as administered on R42's medication administration record (MAR). LPN-B stated R42 was used to doing the nebulizer	21565	medications was revised into 2-sections. One which includes all medications and another which is specific for nebulizers after set up by RN/LPN/TMA. Education regarding this policy was completed to the RN unit managers. An updated assessment was made and is now being utilized by RN unit managers for anyone who is self-administering nebulizers after set up. This assessment is to be done prior to initiating self-administration and quarterly. Assessment done on R42, physician order obtained, consent signed by R42, and care plan updated. A list of residents who are able to self-administer their nebulizers after set up are kept in a binder on each medication cart for cart nurse review. This is to be updated by RN unit manager as appropriate and cart nurse to notify RN unit manager if there are additional residents they feel should be assessed and possibly added to the list. All staff will be educated of revised policy. The new policy will be implemented and the plan of correction will be integrated into the quality assurance program and evaluated for its effectiveness by DON or designee, who will monitor compliance with the policy by auditing once weekly x4 weeks, monthly x3 months, and findings will be brought to QA meeting. The facility alleges that it will be in substantial compliance with the standard indicated by January 4, 2017.	

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21565	Continued From page 30 treatment on her own from when she lived at home and she does not like to have help. LPN-B stated she would consider this self administration of medications and she did not know if there was an assessment, order or care plan in place for R42 to do self administration of her nebulizer treatment. After searching through R42's electronic record, LPN-B confirmed she could not find a SAM assessment for R42. On 11/30/16, at 12:39 p.m. the director of nursing (DON) stated if a resident was to self-administer their nebulizer treatment, their ability should be assessed by a registered nurse and care planned. The DON confirmed R42 had not been assessed for SAM ability and self administration of medication was not identified on R42's care plan and should have been. The undated facility policy titled Self-Administration of Medications indicated residents had the right to self-administer medications if determined safe to do so by the interdisciplinary team. This was also to be re-assessed quarterly, and residents were to sign a statement confirming their wish to self administer medications. SUGGESTED METHOD OF CORRECTION:The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents do not self administer medications until assessed safe to do so. The DON or designee could educate all appropriate staff on these policies and procedures. In addition, the DON	21565		

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21565	Continued From page 31 or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		