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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2BBI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**
2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 October 24, 2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 10/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 01/17/2014 (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
08/01/1987
(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
09/17/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5495

A Standard survey was completed at this facility on July 18, 2013. The most serious deficiency was issued at a S/S Level of D. On July 31, 2013 a Federal Monitoring Survey was completed at this facility. The most serious deficiency was issued at a S/S level of E. As a result of the facility not being in substantial compliance CMS imposed the following:

Mandatory DOPNA, effective October 18, 2013

The facility was subject to a loss of NATCEP for two years beginning October 18, 2013

On October 24, 2013 a PCR was completed to verify correction of the deficiencies issued pursuant to the standard survey and the Federal Monitoring Survey. Based on our revisit, we determined that two deficiencies were not corrected and one new deficiency was issued. The most serious deficiency was issued at a S/S level of D. As a result of this revisit, we recommended the following to the CMS RO for imposition:

Mandatory DOPNA, effective October 18, 2013 remain in effect.

Since DOPNA is in effect, the facility is subject to a Loss of NATCEP for two years beginning, October 18, 2013 Post Certification Revisit to follow.

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7357

November 12, 2013

Ms. Katherine Holland, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, MN 55744

RE: Project Number S5495022 and H5495034

Dear Ms. Holland:

On July 31, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 18, 2013 that included an investigation of complaint number H5495034. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On July 31, 2013, the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found the most serious deficiencies a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). As a result of the FMS, CMS imposed the folliwng remedy:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 18, 2013. (42 CFR 488.417 (b))

On October 24, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 18, 2013 and an FMS completed on July 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 18, 2013 and FMS completed on July 31, 2013. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiency:

F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is recommending to the Region V Office of CMS the following remedy for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 18, 2013 remains in effect. (42 CFR 488.417 (b))

As CMS notified you in their letter of September 11, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 18, 2013.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Patricia Halverson
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Telephone: (218) 302-6151
Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 18, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5495r1_13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245495	A. Building B. Wing	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/27/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **08/27/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/27/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	11/12/2013	29625	10/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/18/2013			

FMS

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245495	A. Building B. Wing	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/11/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/11/2020**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/11/2013**	ID Prefix **F0467** Reg. # **483.70(h)(2)** LSC	Correction Completed **10/11/2013**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	11/12/2013	29625	10/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/29/2013			

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

Federal Revisit

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____ OK 11-15-13 BLH	R Federal 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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	{F 000}	F241 :	11-22-13
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide an adequate cover up for comfort and dignity following a shower for 1of 4 residents (R42) reviewed for dignity. Findings include: R42 diagnoses included cerebrovascular disease, allergic rhinitis, atrial fibrillation, diabetes type 2, esophageal reflux, osteoarthrosis, hyperlipidemia, hemiplegia, hypertension, and venous insufficiency. R42's quarterly minimum data set (MDS) review dated 10/3/13, indicated R42 was cognitively intact, was totally dependent in transferring, required extensive assistance with dressing and personal hygiene activities, and required physical help in part of bathing activity. R42's care plan reviewed 10/8/13, indicated R42 required a hoyer lift and 2 staff for transfers in/out of shower chair and 1 staff for bathing assistance.	{F 241}	1. Corrective Action: a. Employee #A, who had assisted Resident #42 with her shower on 10/22/13 was re-educated on 10/28/13 on the need to fully cover all residents who are not clothed when leaving shower/tub room. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for dignity, which includes warmth with shower/bath was reviewed and revised. b. An Inservice on dignity, to include covering after shower/bath, was held on 11/5 and 11/6/13. 3. Date of Completion: 11/22/13 4. Reoccurrence will be prevented by: a. Visual audits will be conducted 2xweekly on each Unit x 90 days to assure residents are provided adequate covering/warmth after their bath/shower. The results of these audits will be shared with the facility QA Committee for input on the need to increase, decrease, or discontinue the audits.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine A Holland — TITLE: Administrator — (X6) DATE: 11/14/13

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.

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 241}	Continued From page 1 On 10/22/13, at 7:35 a.m. R42 was observed seated in wheeled shower chair being pushed out of community shower room and into hallway of the 400 wing of the facility. Two nursing assistants (NA's) (NA-A and NA-F) were observed to be busily trying to cover exposed areas of R42's thighs and abdominal sides with white bath towels draped around R42's midriff and lap areas. R42's hair was observed to be wet and plastered to [his/her] head. R42 verbalized how cold the hallway felt. One of the 2 NA's was heard to state as they wheeled R42 down the hallway toward R42's room, which was located halfway down the hall from the shower room and a member of the opposite sex was seated in a wheelchair near R42's room doorway, "remember [resident's first name], you still have that lift underneath you." On 10/23/13, at 1:30 p.m. NA-E stated she was not helping R42 with a shower yesterday but was aware R42's family had brought in a large bath towel to use on shower days. NA-E went into R42's closet and retrieved a large, white bath towel. NA-E further stated bath linens are not kept in the shower room but the NA's have access to bath blankets and large, oversized printed fabric ponchos to cover residents during transport from shower room to their own room for dressing. On 10/23/13, at 2:00 p.m. NA-A stated she had assisted R42 with a shower on 10/22/13, and had been aware R42 was not totally covered upon exit from the shower room, into the hallway, and down to R42's room. NA-A confirmed R42 had the large, white bath towel over [his/her] shoulders but should have had something more	{F 241}		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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{F 241}	Continued From page 2 covering [his/her] sides and lap, as to not be so exposed. On 10/23/13, at 3:25 p.m. R42 stated [he/she] is always very uncomfortable when transported out of the shower room and down the hallway to [his/her] own room. R42 further stated the hallway is cold and [he/she] is seated on a cold, wet sling. R42 went on to state [he/she] is naked under those covers and feels cold and exposed being wheeled down the hall to [his/her] room and just does not like it at all. On 10/24/13, at 11:30 a.m. registered nurse (RN)-C stated R42 should not be cold after showering and should be covered up when exiting the shower room. RN-C confirmed those situations are very undignified for R42. A Shower/Tub Bath Level II policy [undated], indicated staff should be sure a resident is appropriately covered so that his/her body will not be exposed and so that he/she will be warm, when being transported to and from the bath area in a bath chair or wheel chair.	{F 241}		
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	F 312		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 3 review, the facility failed to ensure facial hair was removed for 1 of 1 residents (R4) reviewed for activities of daily living (ADL's). Findings include: R4's diagnoses included ventilator dependence, dysphagia, muscle weakness, esophageal reflux, memory loss, anemia, mitral stenosis with insufficiency, congestive heart failure, osteoporosis, cerebral artery occlusion with infarct, and hypertension. R4's quarterly minimum data set (MDS) review dated 9/6/13, indicated R4 had short term memory deficits and required extensive assistance with personal hygiene activities. R4's plan of care for hygiene/ADL's/skin reviewed 9/16/13, lacked an intervention to address R4's facial hair removal. R4's Pocket Care Guide (nursing assistant's care guide) [undated] lacked information to address R4's specific cares needs for facial hair removal. On 10/22/13, at 8:01 a.m. R4 was observed sitting up in wheelchair in [his/her] room, awaiting breakfast. R4 was noted to have many long, white hairs on [his/her] chin. On 10/23/13, at 7:46 a.m. R4 was observed seated in wheelchair in [his/her] room, awaiting breakfast. R4 was noted to have an orange hat on [his/her] head and also had many long, white hairs on [his/her] chin. On 10/23/13, at 3:10 p.m. R4 stated [he/she] was	F 312	F312 1. Corrective Action: a. Resident # 4 chin hair was removed as soon as the concern was identified. This resident has certain preferences for caregivers and often displays behaviors which are troubling for her if her preferences are not honored. Her Care Plan and NAR Care Sheet was updated to indicate to shave her chin hairs each week on Fridays at the time of her bath if she will allow and to document if she refuses. Upon interview with NAR "Angie", she stated Resident had refused chin shaving on the prior Friday in question and that she had reported the refusal to the nurse. It should be noted this Resident discharged from our facility on 11/4/13 to move closer to her daughter. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for ADL assistance, which includes shaving, was reviewed and remains current. b. All Resident's Care Plans and NAR Care Sheets will be	11-22-13

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OMB NO. 0938-0391

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	245495	A. BUILDING _____ B. WING _____	R 10/24/2013

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F 312	Continued From page 4 aware of the chin hairs and further stated "Angie takes care of them." R4 reported [he/she] receives a bath on Fridays when the chin hairs are shaved by "Angie." On 10/24/13, at approximately 10:45 a.m. the acting director of nursing (ADON) stated R4 is very particular about which nursing assistant provides which personal cares and grooming assistance for [him/her]. The ADON and the surveyor entered R4's room. The ADON noted R4's long white chin hairs and requested permission from R4 to trim or shave the hairs which R4 granted to the ADON. The ADON confirmed R4's long, white chin hairs should have been removed prior to this date and were probably about 2 weeks growth. The ADON further stated she was unsure if "Angie" was working or not last Friday, however another nursing assistant should have requested permission to remove the hairs. A Resident Dignity with Cares policy [undated], directed each resident who needs assistance with grooming will receive this assistance, unless otherwise indicated. The policy further directed grooming needs included facial hair care.	F 312	reviewed to assure the assistance needed for ADL's, including shaving, is current. c. An Inservice on ADL assistance to include shaving was held 11/5 and 11/6/13 for all nursing staff. Documenting refusals of care was also a part of this training. 3. Date of Completion: 11/22/13 4. Reoccurrence will be prevented by: a. Visual audits will be held 2 xs weekly on all Units x90 days to assure assistance with ADL's, to include shaving, is being provided according to the Care Plan. The results of these audits will be shared with the Facility QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: Nurse Managers/Designee	

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	245495	A. BUILDING _____ B. WING _____ OK 11-15-13 RCN	R 10/24/2013

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{F 000}	INITIAL COMMENTS A follow-up survey was completed for deficiencies related to Complaint #H5495034. F157 was corrected.	{F 000}	F282 1. Corrective Action: a. Upon interview, the nursing assistant assigned to Resident # 179 (same resident as #164) stated she had repositioned him at 0645 on 10/23/13 according to his care plan, but had not had a chance to document the repositioning time on the Flow Sheet at the nurses station due to the busy morning. She had documented the time on a paper towel from the resident's room and placed it in her pocket so she would have the correct time when she later documented on the Flow Sheet. She stated the resident then turned on his call light at around 0725 and stated he had "shoulder pain" so she then moved a pillow under his shoulder to provide comfort. At 0845 she stated she and the nurse repositioned the resident and wound care was provided. The resident often sits at an angle in bed higher than 30 degrees and in warmer weather spends much time outside in his electric wheelchair. He has been explained the risk/benefit of refusal to allow pressure relief off his coccyx while in both chair and bed, and is reminded of these risks/benefits no less than quarterly at his care conferences.	11-22-13
{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 offer repositioning as directed by the plan of care for 1 of 3 residents (R164) reviewed for pressure ulcers. Findings include: R164's was admitted on 7/9/13, with diagnoses that included quadriplegia, stage 4 pressure ulcer, chronic pain, and esophageal reflux. The Admission Minimum Data Set (MDS) dated 7/22/13, indicated R164 was cognitively intact, was totally dependent for bed mobility and transfers, and was at risk for pressure ulcer development. The MDS identified R164 had 2 Stage 2 pressure ulcers and 1 Stage 4 pressure ulcer. There was a pressure-reducing device on the bed and chair, a turning and repositioning program, as well as nutrition or hydration	{F 282}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine A Holland | TITLE: Administrator | (X6) DATE: 11/14/13

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

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{F 282}	Continued From page 1 programs. A Comprehensive Evaluation of Skin Inspection and Risk Factors dated 7/31/13, indicated R164 had a stage 4 sacral pressure ulcer measuring 3 cm in length by 4 cm in width by 5 cm in depth. The care plan revised 8/27/13, directed mechanical lift and 2 staff for transfers and physical assistance of 1-2 staff for repositioning in bed every two hours. An undated nursing assistant care guide indicated R164 required the use of a hoyer lift for all transfers, had a sacral pressure ulcer, and was to be repositioned side to side in bed every 2 hours. Continuous observations were completed on 10/2313, from 7:15 a.m. to approximately 9:20 a.m.. At 7:18 a.m. 2 laboratory technicians entered R164's room for a blood draw. The acting director of nursing (ADON) entered the room when the technicians finished at approximately 7:20 a.m.. R164 was observed sitting up in bed with the head of the bed elevated to approximately 75 degrees. At 7:27 a.m. R164 activated the call light and licensed practical nurse (LPN)-B provided more water and raised head of the bed to approximately 90 degrees. At 7:33 a.m. nursing assistant (NA)-B entered the room stating, "It's time for a little repo!" NA-B lowered the head of the bed and, from the left side, used a small turning sheet underneath R164 to pull [him/her] towards NA-B, placing a flat pillow under R164's right shoulder and raised the head of the bed back up to	{F 282}	2.Corrective Action as it applies to other residents: a. The Policy and Procedure for following care plans, including repositioning times, was reviewed and remains current. b. All residents will be reviewed to assure their repositioning times and positions are reflected accurately on their care plan and nursing assistant care sheets. c. An Inservice on following care plans, to include repositioning, was held 11/5 and 11/6 for all nursing staff. The Nursing Assistant Care Plan sheets were updated to include a section to document repositioning times and to transfer the information onto the Flow sheets located at the Nurses' stations as they are able throughout the day. The Nursing Assistant Care Plan sheets will be turned in to the nurse at the end of each shift and maintained. 2. Date of Completion: 11/22/13	

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{F 282}	Continued From page 2 approximately 75 degrees. R164 remained sitting up in bed with full pressure on the sacral ulcer until wound care was observed at 9:00 a.m.. On 10/24/13, at 10:45 a.m. registered nurse (RN)-D stated R164 should be turned and repositioned side to side every 2 hours with 2 person assistance to prevent pressure on the sacral pressure ulcer. RN-D confirmed the repositioning of R164's shoulders did not count as a reposition for R164, as it provided relief for R164's shoulder discomfort but did not constitute pressure relieving activity for R164's stage 4 pressure ulcer on the coccyx. On 10/24/13, at 2:13 p.m. the ADON stated R164 had been informed of the risks of prolonged pressure on the stage 4 coccyx ulcer. The ADON confirmed R164 was positioned on the back and not repositioned side to side in bed as directed by the plan of care.	{F 282}	3. Reoccurrence will be prevented by: a. Visual audits will be conducted 2xweekly on all Units at various times x90 days to assure repositioning is occurring according to Care Plans and documented as such. The results of these audits will be shared with the Facility's QA Committee for input on the need to increase, decrease, or discontinue the audits. 4. The Correction will be monitored by: DON/ Nurse Managers/Designee	
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	{F 314}	F314 1. Corrective Action: a. The Nursing Assistant caring for Resident #179 (same resident as #164) stated she had repositioned him at 0645 on the morning of the 23rd of Oct. 2013. She stated she had been busy with other residents and had not documented the repositioning time on the Flow Sheet located at the Nurses' Station, but rather on a paper towel and put it in her pocket in order for her to have the time correct when she later charted it on the Flow Sheet.	11-22-13

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{F 314}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to encourage repositioning for pressure relief related to pressure ulcers for 1 of 3 residents (R164) reviewed for pressure ulcers. Findings include: R164's was admitted on 7/9/13, with diagnoses that included quadriplegia, stage 4 pressure ulcer, chronic pain, and esophageal reflux. The Admission Minimum Data Set (MDS) dated 7/22/13, indicated R164 was cognitively intact, was totally dependent for bed mobility and transfers, and was at risk for pressure ulcer development. The MDS identified R164 had 2 Stage 2 pressure ulcers and 1 Stage 4 pressure ulcer. There was a pressure-reducing device on the bed and chair, a turning and repositioning program, as well as nutrition or hydration programs. A Comprehensive Evaluation of Skin Inspection and Risk Factors dated 7/31/13, indicated R164 was chairfast, at risk for shear and friction, had an existing pressure ulcer, and scored low in mobility and activity. The evaluation further indicated R164 had fragile skin, required assistance with activities of daily living (ADL's), had psychotropic drug use, and had medical devices in place, all of which contributed to R164's pressure ulcer risk. The evaluation	{F 314}	2. Corrective Action as it applies to other residents: a. The Policy and Procedure for caring for pressure ulcers, which includes repositioning according to Care Plan, was reviewed and revised to include attempt for a partial repositioning off affected side if resident will not allow a complete turn off affected side. b. All residents with pressure ulcers will be reviewed to assure their treatments are current, including repositioning times. All residents who refuse to follow their repositioning schedules will have Risk/Benefits explained to them no less than quarterly at their care conferences and will be added to their care plan. Staff will attempt a partial off-loading with pillow when resident will allow. c. An Inservice on pressure ulcer care and repositioning according to care plan was held on 11/5 and 11/6/13 for all nursing staff. d. Every nurse who works at Evergreen Terrace will have a visual return demonstration of wound care with dressing change to assure proper technique is performed. 3. Date of Completion: 11/22/13	

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{F 314}	Continued From page 4 denoted R164 had a stage 4 sacral pressure ulcer measuring 3 cm in length by 4 cm in width by 5 cm in depth. The care plan revised 8/27/13, directed mechanical lift and 2 staff for transfers and physical assistance of 1-2 staff for repositioning in bed every two hours. An undated nursing assistant care guide indicated R164 required the use of a hoyer lift for all transfers, had a sacral pressure ulcer, and was to be repositioned q 2h [every 2 hours] in w/c [wheelchair] and q 2h [every 2 hours] side to side in bed. A toileting and repositioning log dated 10/23/13, indicated R164 was to be repositioned q 2 h [every 2 hours] (side to side in bed). Times hand-written in under "T' were 510, 645, 725 and 843 with "repo" hand-written under the 645, 725 and 843 entries. R164's bedroom door was closed at the beginning of observation on 10/23/13, at 7:15 a.m. At 7:18 a.m. 2 laboratory technicians knocked on R164's door and entered the room for a blood draw. The acting director of nursing (ADON) was rounding with the technicians and entered the room when the technicians finished at approximately 7:20 a.m., R164 was observed sitting up in bed with the head of the bed elevated to approximately 75 degrees. The ADON was observed to offer R164 a drink of	{F 314}	4. Reoccurrence will be prevented by: a. Visual audits will be conducted 2x weekly on all Units x90 days to assure repositioning is occurring per Care Plan and documented times are matching the times the repositioned occurred. Once all nurses have performed their wound care return demonstrations, visual audits on wound care will be completed 2 x weekly on various units at various times x 90 days to assure proper procedure is performed. The results of these audits will be shared with the Facility QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Nurse Managers/Designee	

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{F 314}	Continued From page 5 water and turn on the television. R164 was heard to ask the room door be left open. At 7:27 a.m. R164 activated the call light and licensed practical nurse (LPN)-B knocked and entered the room at 7:29 a.m. R164 was heard to ask for more water and for the head of the bed to be raised a little more. LPN-B raised the head of the bed to approximately 90 degrees, provided R164 with a drink of water, and left the room at 7:30 a.m.. R164 was sitting up in bed with full pressure on the sacral area. At 7:33 a.m. nursing assistant (NA)-B knocked and entered R164's room stating, "It's time for a little repo!" NA-B lowered the head of the bed and, from the left side, used a small turning sheet underneath R164 to pull [him/her] towards NA-B, placing a flat pillow under R164's right shoulder. NA-B raised the head of the bed back up to approximately 75 degrees, turned off the radio per R164's request, and exited the room at approximately 7:35 a.m. On 10/23/13, at 9:00 a.m. LPN-B and NA-C were observed to knock and enter R164's room. LPN-B washed her hands in R164's bathroom sink and donned disposable gloves. NA-C applied disposable gloves and assisted R164 onto the right hip. LPN-B removed the old dressing and wound packing, removed the soiled gloves, applied hand sanitizer to her hands, and donned a new pair of gloves. LPN-B sprayed normal saline into the open ulcer on R164's coccyx area, using gauze dressings to catch the solution and bright red drainage from the ulcer. LPN-B applied pressure to the ulcer, soaking up the red drainage, changing the saturated gauze several times. LPN-B removed soiled gloves	{F 314}		

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{F 314}	Continued From page 6 and washed hands with soap and water, returning to R164's bedside with clean gloves. LPN-B applied normal saline spray solution to gauze dressing, and using a cotton-tipped applicator, packed the sacral ulcer with gauze. LPN-B covered the ulcer with 2 thick gauze dressings taped into place. LPN-B and NA-C applied an incontinent pad to hold the dressing in place and positioned R164 on the back. On 10/24/13, at 10:45 a.m. registered nurse (RN)-D stated R164 should be turned and repositioned side to side every 2 hours with 2 person assistance to prevent pressure on the sacral pressure ulcer. RN-D confirmed the repositioning of R164's shoulders did not count as a reposition for R164, as it provided relief for R164's shoulder discomfort but did not constitute pressure relieving activity for R164's stage 4 pressure ulcer on the coccyx. On 10/24/13, at 2:13 p.m. the ADON stated R164 had been informed of the risks of prolonged pressure on the stage 4 coccyx ulcer. The ADON confirmed R164 was positioned on the back and not repositioned side to side in bed as directed by the plan of care. A skin care/pressure ulcer care policy reviewed and revised 8/09, directed for pressure ulcers treatment to Stage 3 or 4, to position resident off affected area.	{F 314}		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 7 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. (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:	F 441	F441 1. Corrective Action: a. LPN# A that did not follow the proper handwashing/gloving procedure when completing dressing changes was re-educated with return demonstration on 10/28/13. RN #B is no longer employed by Evergreen Terrace. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for wound care, which includes proper handwashing/gloving, was reviewed and remains current. b. An Inservice on Infection Control, to include proper handwashing/gloving was held with all nurses and one-on-one return demonstrations on proper technique with dressing changes is being conducted with each nurse employed by Evergreen Terrace. 3. Date of Completion: 11/22/2013	11-22-13

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F 441	Continued From page 8 Based on observation, interview and document review, the facility failed to utilize proper hand hygiene during dressing changes for 2 of 3 resident (R43, R92) observed for wound care. Findings include: On 10/23/13, at 3:15 p.m. licensed practical nurse (LPN)-A was observed doing a dressing change to a pressure ulcer on R43's right ankle. LPN-A was not observed to wash or sanitize her hands prior to entering R43's room. LPN-A removed R43's sock and, without handwashing, donned gloves to remove the old dressing, cleansed the wound with normal saline, and applied Vaseline to wound edges with a cotton tipped applicator. LPN-A removed the gloves, dated the new foam dressing, removed the backing from the foam dressing and applied the foam dressing to the wound. LPN-A donned clean gloves, applied R43's sock, looked at and touched the stump on the other leg, applied a blue heel boot to R43's foot and pulled up the blanket. LPN-A removed the gloves, opened the door with the handle, and used hand sanitizer in the hallway. At 3:30 p.m., LPN-A stated she was not aware of the requirement to wash hands before applying clean gloves, after removing soiled dressings, and before exiting the resident's room. Registered nurse (RN)-B was observed, on 10/24/13, at 10:30 a.m., during a dressing change to a wound on R92's right foot. RN-A retrieved gloves from the bathroom, set up area	F 441	4. Reoccurrence will be prevented by: a. Visual audits will be conducted 2x weekly on all Units x90 days on nurses completing dressing changes to assure proper handwashing/gloving is occurring once every nurse has completed the one-to-one return demonstration. The results of these audits will be shared with the Facility QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Nurse Managers/Designee	

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 441	Continued From page 9 and supplies and applied gloves without hand sanitization. RN-B bumped the over bed table and a cup of coffee spilled on the floor. RN-B removed the gloves and wiped up the coffee with a towel. The RN took the towel out of room and immediately returned to the room. The RN applied a pair of gloves without washing or sanitizing her hands. The RN then removed the dressing, removed her gloves and applied new gloves. The RN cleaned the wound with normal saline and a two by two inch gauze. The RN then cut a piece of tube gauze with scissors from the R92's container of supplies, packed the wound, covered it with gauze and a foam dressing. The RN then pulled R92's sock over the toes, gathered trash and removed her gloves. The RN put R92's shoe on, put the supplies back in closet, tied up the trash and removed it from can, put in a new bag and moved trash can back over by the bed. The RN then touched her hair, opened door with the handle, exited the room and went to the soiled utility room and rinsed out the coffee soaked towel. At 10:50 a.m. RN-B was interviewed and stated, "I probably washed them [hands] after the last time I did something." RN-B verified she did not wash her hands before entering R92's room or while in the room. The RN stated this was how she usually did dressing changes and does not wash or sanitize her hands between glove changes or before leaving the room. On 10/24 a.m., at 11:20 A.M. the director of nursing (DON) was interviewed on when should the nurses be washing their hands during dressing changes. The DON would expect the nurses to be washing or sanitizing their hands	F 441		

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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	R 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 441	Continued From page 10 between dirty to clean, between glove changes, before entering and exiting the resident's room. The facility Dressing Changes (Dry,Clean) policy (not dated) directed staff to wash and dry hands, put on clean gloves and remove the soiled dressing then wash and dry hands, open dry, clean dressing touching the exterior surface only. Put on clean gloves, clean wound, apply the ordered dressing and secure, remove gloves and wash and dry hands.	F 441		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2BBI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00299

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245495**
2.STATE VENDOR OR MEDICAID NO.
(L2) **606318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVERGREEN TERRACE**
(L4) **2801 SOUTH HIGHWAY 169**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **07/18/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Ann Hyrkas, HFE NEII 08/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(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
Posted 9/17/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5495

At the time of the July 18, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. In addition, at the time of the standard survey, an investigation of complaint number H5495034 and found to be substantiated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2864

July 31, 2013

Ms. Katherine Holland, Administrator
Evergreen Terrace
2801 South Highway 169
Grand Rapids, Minnesota 55744

RE: Project Number S5495022 and H5495034

Dear Ms. Holland:

On July 18, 2013, 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. In addition, at the time of the standard survey the Minnesota Department of Health completed an investigation of complaint number. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 723-4637

Fax: (218) 723-2359

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 August 27, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 18, 2013 (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 January 18, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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:

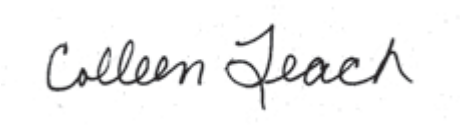
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 07/31/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 PLAN OF CORRECTION (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. Census 86 An investigation of complaint H5496034 was completed. The complaint was substantiated with a deficiency issued at tag F157.	F 000	OK 8-13-13 PLN	8-27-13
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157	F 157 1. Corrective Action: a. Resident #94 family was notified of resident's change in skin condition. 2. Corrective Action as it applies to other resident: a. The Policy and Procedure for family notification was reviewed and remains current. b. All residents with condition changes will be reviewed to assure family notification has occurred. c. An In-service on family notification for changes in condition was held on 8/6 & 8/7/2013 for all licensed nurses.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine Ackland — TITLE: Administrator — (X6) DATE: 8/9/13

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.

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

FORM APPROVED
OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND 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 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification to the physician and family of a significant change in skin condition for 1 of 1 residents (R94). Findings include: R 94's diagnoses included end stage renal disease, hypertension, diabetes mellitus type 2, anemia, diabetic retinopathy, neurogenic bladder, and depressive disorder. R94's quarterly minimum date set (MDS) dated 4/19/13, indicated R94 was cognitively intact, was at risk for the development of pressure ulcers, and had no healed or unhealed pressure ulcers.	F 157	3. Date of Completion: 8/27/13 4. Reoccurrence will be prevented by: a. All resident changes in condition are documented on the 24 hour report. To assure family notification, a space will be added to the 24 hour report to indicate such. Daily X 90 days, residents with change in condition will be audited to assure family notification occurred. The results of these audits will be reviewed by the QA Committee and input given on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 2 An electronic progress note dated 2/16/13, indicated R94 had a pressure ulcer care area assessment (CAA) related to R94 needing assistance with bed mobility and was at risk for the development of pressure ulcers. The pressure ulcer CAA further indicated R94 received extensive assistance of 1 to 2 staff to reposition R94 when in bed and extensive assistance of 1 staff to off-load [relieve pressure] when R94 was up in a wheelchair. The pressure ulcer CAA also noted R94 had no current skin issues along with repositioning required every 2 hours by staff, had a pressure reducing mattress on the bed and a pressure reducing cushion in the wheelchair. The pressure ulcer CAA further indicated staff were to observe R94's skin daily with cares and R94's skin was to be inspected by licensed staff weekly with a shower/bath. An electronic progress note dated 7/5/13, indicated R94's right heel ulcer was improving, however, the right buttock area was noted to have 3 boil-like areas, with 2 of the areas draining yellow/white pus. A weekly wound documentation form dated 7/5/13, indicated R94 had both an abrasion on the right buttock area and boil-like lesions on the right sacrum and right gluteal fold areas with drainage noted to be scant in amount, serosanguinous in type. An electronic progress note dated 7/8/13, indicated R94's physician had been made aware	F 157		

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

RECEIVED
AUG 12 2013
MN Dept of Health Duluth

PRINTED: 07/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

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F 157	Continued From page 3 of the change in R94's sacral pressure ulcer during nursing home rounds. On 7/18/13, at 4:30 p.m. the director of nursing (DON) was interviewed and stated R94's family and physician should have been notified on 7/5/13, of the change in condition of R94's ulcers. The DON confirmed an incident report or nurses progress note could not be located indicating notification had occurred. The facility's change of condition policy reviewed and revised 3/2013, directed a change in skin integrity was to be assessed and reported to the resident's physician in a timely manner. The change of condition policy further directed a change in status of a resident was to be reported to the resident's designated contact person/family significant other.	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278	F 278 1. Corrective Action: a. The catheter was added to resident #70 MDS. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for completing the MDS was reviewed and remains current. b. All residents will have their most recent MDS reviewed to assure accuracy in coding c. An In-service on accurately completing the MDS was held on 8/2 & 8/6/2013 with the MDS Nurses. 3. Date of Completion: 8/27/13	8-27-13

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F 278	Continued From page 4 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the Minimum Data Set (MDS) assessment was accurate for 1 of 1 residents (R70) who had an indwelling urinary catheter. Findings include: R70's diagnoses included end stage chronic obstructive pulmonary disease (COPD), left lung mass (2/2013), diabetes, anxiety, psychotic disorder, and respiratory failure. A Progress Note dated 5/10/13, indicated R70 was re-admitted from the hospital with an indwelling urinary catheter in place. On 7/17/13, at 7:42 a.m. and on 7/18/13, at 9:01 a.m. R70 was observed in the room and had an	F 278	4. Reoccurrence will be prevented by: a. A minimum of 4 MDS's will be audited weekly for 90 days to assure accurate coding. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	

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F 278	Continued From page 5 indwelling urinary catheter. The significant change Minimum Data Set (MDS) dated 5/30/13, indicated R70 had severe cognitive impairment; was independent with bed mobility, transfers, and ambulation; required supervision with eating, and toilet use; and required extensive assistance with dressing, and personal hygiene. The MDS did not identify R70 had an indwelling urinary catheter. The Care Area Assessment (CAA) dated 5/30/13, indicated R70 was independent with all areas of mobility, was continent of bowel and bladder, and was able to toilet herself. The CAA did not identify R70 had an indwelling urinary catheter. On 7/18/13, at 10:00 a.m. the registered nurse (RN)-A confirmed the MDS was inaccurate and did not identify R70 had a catheter. RN-A stated an error was made and verified the catheter should have been identified on the MDS.	F 278		8-27-13
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 provide every 2 hour repositioning interventions to reduce the risk of pressure ulcers as directed by the plan of care for	F 282	F 282 1. Corrective Action: a. The staff responsible for timely repositioning of resident # 164 was counseled and re-educated. 2. Corrective Action as it applies to other resident: a. The Policy and Procedure for repositioning was reviewed and remains current. b. All Residents care plans will be reviewed for accuracy c. An In-service on repositioning was held 8/6 & 8/7/13 for all nursing staff. d. An inservice on care plans will be held August 15 & 16, 2013	

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F 282	Continued From page 6 1 of 3 residents (R164) reviewed for pressure ulcers. Findings include: R164's diagnoses included acute venous embolism and thrombosis of lower extremity vessels, chronic pain, colostomy, neurogenic bladder and bowel, anemia and quadriplegia. R164's care plan date initiated 7/15/13, indicated R164 had a skin issue to the sacrum, low back, and right outer ankle and buttocks from pressure and directed R164 to be turned and repositioned every 2 hours. R164's care plan date initiated 7/15/13, directed R164 required extensive assistance of 2 staff with bed mobility and transfers. A Pocket Care Plan [updated] noted R164 had a sacral ulcer along with ulcers on the low back and right lateral ankle and directed R164 to be repositioned every 2 hours while in the wheelchair and side to side while in bed. A Toileting and Repositioning Log dated 7/17/13, days, indicated R164 was to be repositioned every 2 hours side to side in bed. On 7/17/13, from 7:20 a.m. to 9:58 a.m. continuous observation occurred in the hallway outside of R164's room with R164's room door closed.	F 282	3. Date of Completion: 8/27/13 4. Reoccurrence will be prevented by: a. A minimum of 4 MDS's will be audited weekly for 90 days to assure accurate coding. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits 5. The Correction will be monitored by: DON/Designee	

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F 282	Continued From page 6 1 of 3 residents (R164) reviewed for pressure ulcers. Findings include: R164's diagnoses included acute venous embolism and thrombosis of lower extremity vessels, chronic pain, colostomy, neurogenic bladder and bowel, anemia and quadriplegia. R164's care plan date initiated 7/15/13, indicated R164 had a skin issue to the sacrum, low back, and right outer ankle and buttocks from pressure and directed R164 to be turned and repositioned every 2 hours. R164's care plan date initiated 7/15/13, directed R164 required extensive assistance of 2 staff with bed mobility and transfers. A Pocket Care Plan [updated] noted R164 had a sacral ulcer along with ulcers on the low back and right lateral ankle and directed R164 to be repositioned every 2 hours while in the wheelchair and side to side while in bed. A Toileting and Repositioning Log dated 7/17/13, days, indicated R164 was to be repositioned every 2 hours side to side in bed. On 7/17/13, from 7:20 a.m. to 9:58 a.m. continuous observation occurred in the hallway outside of R164's room with R164's room door closed.	F 282	3. Date of Completion: 8/27/13 4. Reoccurrence will be prevented by: a. Visual audits of 2 residents per week on different Units X 90 days will be completed to assure repositioning needs are being met timely per care plan. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	

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F 282	Continued From page 7	F 282		

On 7/17/13, at 9:38 a.m. nursing assistant (NA)-C knocked on R164's door, opened the door and looked for the hoyer lift. NA-C was observed to not go all the way into R164's room, did not locate the hoyer lift, and exited the room shutting the door.

On 7/17/13, at 9:58 a.m. NA-A knocked and entered R164's room to provide R164 with morning cares. R164 was observed to be laying on the bed, positioned on the right side with a pillow under the left side. NA-A removed the pillow and positioned R164 on the back.

On 7/17/13, at 10:17 a.m. registered nurse (RN) -B knocked and entered R164's carrying the dressing change supplies. RN-B was observed to exit and re-enter the room 2 more times for dressing change supplies. At 10:28 a.m. RN-B had gathered all the needed supplies and was ready to perform wound care and dressing changes to R164's various ulcers and wounds.

On 7/17/13, at 11:15 a.m. NA-C knocked and entered R164's room pushing the hoyer lift into the room. NA-C and RN-A used the hoyer lift to transfer R164 into the wheelchair.

On 7/17/13 at 1:36 p.m. NA-C was interviewed and referred to the Turning and Repositioning Log for R164. NA-C confirmed the 800 written on the log meant R164 was repositioned at 8:00 a.m. and stated she did not turn or reposition R164 that am and did not write the 8:00 a.m. reposition on the log. NA-C further stated she was not sure

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F 282	Continued From page 8 who had written 8:00 a.m. or who might have turned or repositioned R164. NA-C verified R164's turning and repositioning schedule was ordered for every 2 hours, side to side, while in bed. On 7/17/13, at 1:47 a.m. NA-B was interviewed and stated [he/she] wrote 800 on the repositioning log. NA-B further stated [he/she] came on duty at 6:00 a.m., checked in on R164 but did not provide any turning or repositioning. NA-B also stated R164 was due to be turned and repositioned around 8:00 a.m. and reminded the other 2 NA's working day shift this date when R164's was due for repositioning. NA-B stated R164 was suppose to be turned and repositioned every 2 hours and verified R164 was not repositioned as ordered. On 7/17/13, at 2:42 p.m. RN-B made a phone call to NA-A. On speaker phone, NA-A was heard to say [he/she] did not provide turning and repositioning to R164 this morning until entering R164's room around 10:00 a.m. to provide R164 with morning cares. On 7/17/13, at 3:35 p.m. the director of nursing (DON) stated R164 should have been turned and repositioned every two hours as directed by the plan of care. A Skin Care/Pressure Ulcer Care policy and procedure reviewed and revised 8/2009, directed turning and repositioning of all residents with potential and/or actual impairment in skin integrity should be every 2 hours while in bed and at least hourly when in the chair. 1	F 282		

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to reduce the risk of pressure ulcers for 1 of 3 residents (R164) reviewed for pressure ulcers. Findings include: R164's diagnoses included acute venous embolism and thrombosis of lower extremity vessels, chronic pain, colostomy, neurogenic bladder and bowel, anemia and quadriplegia. A Comprehensive Evaluation of Skin Inspection and Risk Factors dated 7/9/13, identified R164 had a Braden Risk score of 13, was chairfast and immobile, was at risk for shear and friction, and had an existing pressure ulcer. The skin assessment further noted R164 required assistance with activities of daily living, had fragile skin, and had a history of pressure ulcers and	F 314	F 314 1. Corrective Action: a. The staff responsible for timely repositioning of resident # 164 were counseled and re-educated. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for repositioning was reviewed and remains current. b. All residents needing assistance with repositioning needs will be reviewed to assure their repositioning schedule is current and is reflected on their care plan and care sheets. c. An In-service on repositioning was held on 8/6 & 8/7/2013 for all nursing staff. 3. Date of Completion: 8/27/13	8-27-13

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F 314	Continued From page 10 scarring to to bilateral buttocks. The area of skin inspection results on the 7/9/13, skin assessment form indicated R164 had a 3 cm in length by 2 cm in width by 4 cm in depth stage 4 pressure ulcer on the sacrum. The are a of skin inspection results on the 7/9/13, skin assessment form also noted R 164 to have a 3 cm by 2 cm by 0.1 cm stage 2 pressure ulcer on the right outer ankle along with a 0.3 cm by 1.0 cm pressure ulcer on the lower back [not staged]. The analysis of risk factors and interventions area on the 7/9/13, skin assessment form described the pressure ulcer on R164's sacrum as deep with undermining between 9 to 12 cm and directed interventions of completion of dressing changes as ordered and repositioning ever 1 hour while up in the wheelchair and every 2 hours side to side while in bed. R164's care plan date initiated 7/15/13, indicated R164 had a skin issue to the sacrum, low back, and right outer ankle and buttocks from pressure and directed R164 to be turned and repositioned every 2 hours. R164's care plan date initiated 7/15/13, directed R164 required extensive assistance of 2 staff with bed mobility and transfers. A Pocket Care Plan [updated] noted R164 had a sacral ulcer along with ulcers on the low back and right lateral ankle and directed R164 to be repositioned every 2 hours while in the wheelchair and side to side while in bed. A Toileting and Repositioning Log dated 7/17/13, days, indicated R164 was to be repositioned	F 314	4. Reoccurrence will be prevented by: a. Visual audits of 2 residents on all 3 shifts per week randomly chosen from all unit X 90 days will be completed to assure repositioning needs are being met timely per care plan. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	

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F 314	Continued From page 11 every 2 hours side to side in bed and listed under the time column were hand written entries of 0511, 0800, and 0951. On 7/17/13, from 7:20 a.m. to 9:58 a.m. continuous observation occurred in the hallway outside of R164's room with R164's room door closed. No one entered the room for 2 hours and 38 minutes). On 7/17/13, at 9:38 a.m. nursing assistant (NA)-C knocked on R164's door, opened the door and looked for the hoyer lift. NA-C did not go all the way into the room, the hoyer lift was not there and NA-C left the room and closed the door. On 7/17/13, at 9:58 a.m. NA-A knocked and entered R164's room to provide morning cares. R164 was observed to be laying on the bed, positioned on the right side with a pillow under the left side. NA-A removed the pillow and positioned R164 on the back. On 7/17/13, at 10:17 a.m. registered nurse (RN) -B knocked and entered R164's carrying the dressing change supplies. RN-B was observed to exit and re-enter the room 2 more times for dressing change supplies and started wound care and dressing changes to R164's various ulcers and wounds. On 7/17/13, at 10:28 a.m. NA-A turned R164 to the right while RN-B provided ulcer care to the sacral and lower back areas. RN-B removed the	F 314		

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F 314	Continued From page 12 old dressings and measured the wound at 3.5 cm in length by 1.8 cm in width by 3.2 cm in depth and stated R164's sacral ulcer was a stage 4 pressure ulcer; 90% granulation tissue and 10% slough; a moderate amount of serous drainage with no odor present; and had undermining at the 9 o'clock to 12 o'clock position of 8.2 cm. Appropriate wound care and dressing application was observed. After hand hygiene, RN-B cleansed the left lower back ulcer area with normal saline spray, dried the area with a gauze and applied a small, foam dressing. RN-B stated the lower back ulcer was healed and the foam dressing was applied for protection of the area as it is located on a scar. RN-B performed hand hygiene and applied new gloves and removed the pink Allevyn dressing from R164's right outer ankle pressure ulcer. RN-B then measured R164's right outer ankle pressure ulcer at 2.2 cm in length by 2.0 cm in width and stated the right outer pressure ulcer is a stage 1 and applied an allevyn dressing. NA-A assisted R164 to return to a back-laying position in the bed. RN-B provided care to R164's left great toe and then the right great toe where R164 had both great toe nails removed several weeks ago. The wound care procedures were completed at approximately 11:15 a.m. NA-C and RN-A assisted R164 via hoyer lift into the wheelchair at 11:15 a.m. On 7/17/13 at 1:36 p.m. NA-C was interviewed and referred to the Turning and Repositioning Log for R164. NA-C confirmed the 800 written on the log meant R164 was repositioned at 8:00 a.m. and stated she did not turn or reposition R164 that am and did not write the 8:00 a.m. reposition on the log. NA-C further stated she was not sure who had written 8:00 a.m. or who might have	F 314		

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F 314	Continued From page 13 turned or repositioned R164. NA-C verified R164's turning and repositioning schedule was ordered for every 2 hours, side to side, while in bed. On 7/17/13, at 1:47 a.m. NA-B was interviewed and stated [he/she] wrote 800 on the repositioning log. NA-B further stated [he/she] came on duty at 6:00 a.m., checked in on R164 but did not provide any turning or repositioning. NA-B also stated R164 was due to be turned and repositioned around 8:00 a.m. and reminded the other 2 NA's working day shift this date when R164's was due for repositioning. NA-B stated R164 was suppose to be turned and repositioned every 2 hours and verified R164 was not repositioned as ordered. On 7/17/13, at 2:42 p.m. RN-B made a phone call to NA-A. On speaker phone, NA-A was heard to say [he/she] did not provide turning and repositioning to R164 until around 10:00 a.m. when morning cares were completed. On 7/17/13, at 3:35 p.m. the director of nursing (DON) stated R164 should have been turned and repositioned every two hours as directed by the plan of care. A Skin Care/Pressure Ulcer Care policy and procedure reviewed and revised 8/2009, directed turning and repositioning of all residents with potential and/or actual impairment in skin integrity should be every 2 hours wile in bed and at least hourly when in the chair.	F 314		

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	245495	A. BUILDING _____ B. WING _____	07/18/2013

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F 315 F 315 SS=D	Continued From page 14 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure 1 of 1 residents (R70) were comprehensively assessed and had documented medical justification for the continued use of an indwelling urinary catheter. Findings include: R70's diagnoses included end stage chronic obstructive pulmonary disease (COPD), left lung mass (2/2013), diabetes, anxiety, psychotic disorder, and respiratory failure. A Progress Note dated 5/8/13, indicated R70 was hospitalized for shortness of breath (SOB). A Progress Note dated 5/10/13, indicated R70 returned to the facility with an indwelling urinary catheter in place from the hospital stay. Hospital Discharge Instructions, hospital Progress Notes,	F 315 F 315	F 315 1.Corrective Action: a. Resident #70 catheter was discontinued on 7/18/13. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for appropriate diagnosis for the use of an indwelling catheter was reviewed and remains current. b. All residents with indwelling catheters will be reviewed to assure they have an acceptable diagnosis or condition for use. Any Resident who handles their own catheter bag will be educated on proper placement. c. An In-service on acceptable diagnosis/conditions for use of an indwelling catheter was held on 8/6 & 8/7/13 for all licensed nurses. 3. Date of Completion: 8/27/13	8-27-13

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F 315	Continued From page 15 and H& P (history and physical) Notes did not identify R70 had an indwelling urinary catheter, and there were no physician's orders regarding the catheter. A Hospice Clinical Note indicated R70 received Hospice services for terminal illness starting 5/15/13. A Bladder Assessment dated 5/15/13, indicated R70 was continent of urine, able to feel the urge to go to the bathroom, and "toilets independently." R70 would use the call light to request assistance if needed and had a commode at the bedside when short of breath and cannot walk to the bathroom. The assessment did not address R70 had an indwelling urinary catheter. The significant change Minimum Data Set (MDS) dated 5/30/13, indicated R70 had severe cognitive impairment; was independent with bed mobility, transfers, and ambulation; required supervision with eating, and toilet use; and required extensive assistance with dressing, and personal hygiene. The MDS did not identify R70 had an indwelling urinary catheter. The Care Area Assessment (CAA) dated 5/30/13, indicated R70 was independent with all areas of mobility, was continent of bowel and bladder, and was able to toilet herself. The CAA did not identify R70 had an indwelling urinary catheter. The medical records lacked an assessment to evaluate and address the indwelling urinary catheter use and there was no documented medical justification for use of the catheter. A Progress Note and a Hospice Note dated 5/20/13, indicated R70's friend had a concern over R70's "anxiety" over the catheter, and had asked if the catheter could be removed. The notes further indicated when removal of the	F 315	4. Reoccurrence will be prevented by: a. All new residents with indwelling catheters and any new orders for indwelling catheters will be audited X 90 days to assure the MD has given an acceptable diagnosis/condition for use. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	

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F 315	Continued From page 16 catheter was discussed with R70 she initially stated she wanted it removed, but "after some conversation", and "a lot of education" R70 decided she would wait and keep it "for now." A Hospice Note dated 6/16/13, indicated R70 had called the Hospice nurse "very excited" because she thought her catheter was not working, and it needed to be changed. Another 6/16/13, Hospice Note indicated the Hospice nurse contacted the facility nurse and the facility nurse informed her R70 had the catheter tubing wrapped around her legs earlier, staff untwisted it, and it was working just fine. On 7/17/13, at 7:42 a.m. R70 was observed in the room lying on top of the bed. R70 was dressed and had oxygen on via nasal cannula. A urinary catheter bag was hanging on a commode directly next to the upper right side of the bed. R70 stated "I can do all my own cares", and sat up on the side of the bed and stood up. R70 ambulated in the room carrying the urinary catheter bag to the closet and then to the dresser. R70 obtained a pair of gripper socks and ambulated to a chair in the room, and sat down. R70 dropped the urinary catheter bag directly on the floor by the chair and placed the gripper socks on her feet. No excessive SOB was noted during the observation. On 7/18/13, at 9:01 a.m. R70 was in the room sitting in a chair. The urinary catheter bag was directly on the floor beside the chair. R70 stated no one had ever told her not to place the urinary catheter bag on the floor. R70 added, she wanted the catheter taken out and the facility would not take it out. R70 stated she was unsure why she had the catheter and didn't like it because "it was	F 315		

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F 315	Continued From page 17 uncomfortable." On 7/18/13, at 9:35 a.m. the RN manager (RN)-D confirmed R70 had not been assessed for the use of the catheter. RN-D stated when R70 returned from the hospital (5/10/13), she returned with the catheter. RN-D stated she assumed Hospice would address it. RN-D verified an assessment should have been completed and stated she was unable to locate any further documentation regarding the indwelling urinary catheter in R70's medical records. The Policy and Procedure for Completing Incontinence Assessments and Plans of Care dated 7/2006, indicated each resident would have a comprehensive bladder assessment completed upon admission, annually, with a significant change in condition, and with any change in their incontinence/toileting needs.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	F329 1. Corrective Action: a. Resident #23 Pepcid was discontinued on 7/22/13. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for medication review for indications of use was reviewed and revised.	8-27-13

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F 329	Continued From page 18 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not identify, assess, and monitor, clinical indications for continued use of a stomach acid reducing medication for 1 of 10 residents (R70) whose medications were reviewed. Findings include: R23 received famotidine (Pepcid) 20 milligrams (mg) every evening (reduces stomach acid) since 6/10/10, with no documentation from the physician of indications for continued use of the medication. R23's diagnosis included history of a peptic ulcer. The quarterly Minimum Data Set (MDS) dated 4/24/13, indicated R23 had no cognitive impairment. The MDS did not identify R23 had any gastrointestinal diagnoses. A Discharge Summary dated 6/10/10, indicated	F 329	b. An In-service on documentation of sliding scale Insulin and indication for use for medications was held on 8/6 & 8/7/13 for all licensed nurses. 3. Date of Completion: 8/27/13. 4. Reoccurrence will be prevented by: a. The Consultant Pharmacist will be educated on reviewing long term medication to assure indications for use are current. An audit of all monthly Pharmacist reviews will be conducted for 90 days as well to assure medications such as Pepcid have indications for use if given over a longer period of time. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Consultant Pharmacist.	

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F 329	Continued From page 19 R23 was admitted to the facility with physician's orders for Pepcid 20 mg daily. The current physician's orders dated 7/1/13, directed Pepcid 20 mg at bedtime every day for peptic ulcer. The Medication Administration Records for June and July 2013, indicated R23 received the medication every evening at 8:00 p.m. A nurse practitioner note dated 5/6/13, indicated R23 had been refusing her medications and complaining of upset stomach and nausea. R23 was on the Pepcid. R23 denied any abdominal pain, heartburn, or reflux symptoms. It was noted R23 had a recent increase in dose of another medication (Aricept - for dementia), and it was felt the gastrointestinal upset and nausea was likely related to the recent increase in dose so the Aricept was discontinued. The medical records lacked evidence R23 had any other gastrointestinal symptoms, and there was no documentation from the physician for clinical indications for continued use of the medication. On 7/18/13, at 2:00 p.m. the RN manager (RN)-D confirmed the medical records lacked documentation from the physician for the continued use of the medication. On 7/18/13, at 1:55 p.m. the consultant pharmacist (CP) stated he would expect to see a diagnosis of gastroesophageal reflux disease (GERD) for long term use of the Pepcid.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 333	Continued From page 20 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure sliding scale insulin was administered and documented for 1 of 10 residents (R48) reviewed for unecessary medications. Findings included: R48 had diagnoses that included diabetes, acute and chronic renal failure and chronic dependence on a respirator via tracheostomy. Physician orders signed 7/1/13, included Chemstrips (blood glucose monitoring) four times every day with Novolog insulin before meals and at bedtime as needed per sliding scale. Parameters for the administration of the sliding scale Novolog insulin starting on 12/21/12, were as follows: 100 - 150 = 2 units 151 - 200 = 4 units 201 - 250 = 6 units 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 12 units 401 - 450 = 14 units above 451 = 20 units and call the physician. Review of the electronic medication	F 333	F 333 1. Corrective Action: a. The sliding scale Insulin was administered per MD order for Resident #48. The issue discovered was periodic failure to document the amount on the e-MAR. 2. Corrective Action as it applies to other resident: a. The Policy and Procedure for administering Insulin, including documentation of amounts for sliding scales was reviewed and revised on 8/2/13. b. All residents receiving sliding scale Insulin will have their e-MAR reviewed to assure there is a nursing order to document the amount given as well as the blood sugar result. c. An In-service on documenting sliding scale Insulin on the e-MAR was held on 8/6 & 8/7/13 for all licensed nurses.	8-27-13

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F 333	Continued From page 21 administration record (EMAR) from 4/1/13, through 7/17/13, indicated that blood glucose levels were consistently within the parameters to require sliding scale insulin administration; however, sliding scale insulin was not consistently administered as directed by the physician ordered sliding scale. During the month of 4/13, for the 7:00 a.m. blood glucose, the EMAR lacked evidence of sliding scale insulin administered for elevated blood glucose on 11 of 30 days. For the 11:00 a.m. blood glucose, there was no evidence of sliding scale insulin administration for elevated blood glucose for 13 of 30 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 25 of 30 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 28 of 30 days. During the month of 5/13, the 7:00 a.m. blood glucose record lacked evidence of sliding scale insulin administration for elevated blood glucose on 17 of 31 days. For the 11:00 a.m. there was no documentation of sliding scale insulin administration for elevated blood glucose for 17 of 31 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 18 of 31 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 20 of 31 days.	F 333	3. Date of Completion: 8/27/13 4. Reoccurrence will be prevented by: a. Daily medication audit reports will be printed and review by DON/designee x 90 days. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Consultant Pharmacist.	

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F 333	Continued From page 22 During the month of 6/13, R48 was hospitalized for seven days. For the 7:00 a.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 14 of 23 days. For the 11:00 a.m. there was no documentation of sliding scale insulin administration for elevated blood glucose for 17 of 23 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 17 of 23 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 18 of 23 days. During this month R48 was hospitalized for seven days. From 7/1/13, through 7/17/13, for the 7:00 a.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 4 of 17 days. For the 11:00 a.m. there was no documentation of sliding scale insulin administration for elevated blood glucose for 6 of 17 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 11 of 16 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 11 of 16 days. The registered nurse (RN)-C, interviewed on 7/18/13, at 12:50 p.m., stated that all sliding scale insulin should be documented on the EMAR. RN-C stated the amount was not recorded because, "You have to click a few more boxes and physically enter the amount..."	F 333		

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F 333	Continued From page 23 On 7/18/13, at 1:07 p.m. the director of nursing (DON) verified that the sliding scale insulin was not documented. The DON stated that in was a medication error if not documented. The facility's (undated) Preparation and General Guidelines policy indicated the individual who administers the medication dose records the administration on the resident's EMAR directly after the medications given. In no case should the individual who administered the medications report off duty without first recording the administration of medications. The consultant pharmacist (CP) was interviewed on 7/18/13, at 1:55 p.m. and stated that when any medication administration is not documented, "It's an omitted dose. Should be recorded somewhere." The CP stated he did not notice the insulin was not documented.	F 333		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 334	F 334 1. Corrective Action: a. The Immunization consent has been revised to include education given.	8-27-13

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F 334	Continued From page 24 immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 334	2. Corrective Action as it applies to other residents: a. The Policy and Procedure for vaccination education was reviewed and revised. b. All resident who have received a Pneumovax vaccination in 2013 will be provided the 2012-2013 VIS. c. An In-service on vaccination education was held for all licensed nurses on 8/6 & 8/7/13. 3. Date of Completion : 8/27/13 4. Reoccurrence will be prevented by: a. All residents receiving the Pneumovax vaccination plus Influenza vaccination will be audited for the next 90 days to assure the VIS education was given and copy maintained with date of education indicated. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits.	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245495	A. BUILDING _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN TERRACE	2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744

(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 334	Continued From page 25 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure 4 of 5 residents (R3, R92, R100, R102) were offered a Pneumococcal vaccination, and/or received the Influenza vaccination, and/or were provided education on the Influenza and Pneumococcal vaccines. Findings include: R3's medical records lacked documentation to indicate an Influenza vaccination was administered as requested, or if a Pneumococcal vaccination had ever been received, or offered and refused. R3 was admitted to the facility on 5/9/12. The Pneumococcal, Tetanus-Diptheria, and Annual Influenza Vaccine(s) form was signed by R3's representative on 10/6/12, and included education regarding all of the vaccines. The record indicated R3's representative requested the annual Influenza vaccine to be given; however, no documentation was provided to indicate R3 had received the Influenza vaccine. In addition, the form was incomplete and lacked	F 334	5. The Correction will be monitored by: DON/Consultant Pharmacist.	

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F 334	Continued From page 26 evidence the Pneumococcal vaccine was received, or offered and refused. R92's medical records lacked documentation to indicate a Pneumococcal vaccination had ever been received, or offered and refused. R92 was admitted to the facility on 1/19/13. The Pneumococcal, Tetanus-Diptheria, and Annual Influenza vaccine(s) form was signed by R92 on 9/12/12, and included education regarding all of the vaccines. The record indicated R92 refused the Influenza vaccine. The form was incomplete and lacked evidence the Pneumococcal vaccine was received, or offered and refused. R100's medical records lacked documentation to indicate education was provided regarding the benefits and the potential side effects of the Influenza and Pneumococcal vaccinations, and there was no indication the Pneumococcal vaccination had ever been received, or offered and refused. R100 was admitted to the facility on 1/31/12. The Immunization Audit Report indicated R100 was offered the influenza vaccine on 10/4/12, and refused. The report further indicated education had not been provided. In addition, the medical records lacked evidence education was provided regarding the Pneumococcal vaccine, or if the vaccine was received, or offered and refused. R102's medical records lacked documentation to indicate a Pneumococcal vaccination had ever been received, or offered and refused. R102 was admitted to the facility on 3/19/12. The Pneumococcal, Tetanus-Diptheria, and Annual Influenza vaccine(s) form was signed by R92's representative on 9/13/12, and included education regarding all of the vaccines. The	F 334		

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F 334	Continued From page 27 record indicated R102 received the Influenza vaccine on 9/19/12. The form was incomplete and lacked evidence the Pneumococcal vaccine was received, or offered and refused. On 7/18/13, at 1:48 p.m. the director of nursing (DON) confirmed the above findings and stated she had no further documentation to provide. The Immunization Policy updated 2013, indicated education would be provided to residents and/or legal representatives regarding the benefits and potential side effects of the Influenza and Pneumococcal immunizations. The Influenza vaccine would be offered in the fall through March 31, annually, and the Pneumococcal vaccine would be offered if needed. Documentation in the medical record would include the education provided on the vaccines, and if the vaccine was given, refused, or contraindicated. The policy further indicated a second Pneumococcal vaccine may be given after five (5) years following the first, unless contraindicated or refused.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist: The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 1. Corrective Action: a. Resident #23 Pepcid was discontinued on 7/22/13. b. Resident #48 received the sliding scale Insulin per MD order; however the documentation did not indicate the number of units.	8-27-13

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F 428	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist (CP) did not identify and report irregularities in the drug regimen for 2 of 10 residents (R48, R70) reviewed medications. Findings included: R48 had diagnoses that included diabetes, acute and chronic renal failure and chronic dependence on a respirator via tracheostomy. Physician orders signed 7/1/13, included Chemstrips (blood glucose monitoring) four times every day with Novolog insulin before meals and at bedtime as needed per sliding scale. Parameters for the administration of the sliding scale Novolog insulin starting on 12/21/12, were as follows: 100 - 150 = 2 units 151 - 200 = 4 units 201 - 250 = 6 units 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 12 units 401 - 450 = 14 units above 451 = 20 units and call the physician. Review of the electronic medication administration record (EMAR) from 4/1/13, through 7/17/13, indicated that blood glucose levels were consistently within the parameters to require sliding scale insulin administration; however, sliding scale insulin was not consistently	F 428	2. Corrective Action as it applies to other residents: a. The Policy and Procedure for medication review and documentation of medication was reviewed and revised. b. All residents receiving sliding scale Insulin will be reviewed to assure the amounts given are documented on the e-MAR. The Consultant Pharmacist will review all resident current medication orders to assure they have indications for use for any long term medication. c. An In-service on documentation of sliding scale Insulin and indication for use for medications was held on 8/6 & 8/7/13 for all licensed nurses. 3. Date of Completion: 8/27/13.	

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F 428	Continued From page 29 administered as directed by the physician ordered sliding scale. During the month of 4/13, for the 7:00 a.m. blood glucose, the EMAR lacked evidence of sliding scale insulin administered for elevated blood glucose on 11 of 30 days. For the 11:00 a.m. blood glucose, there was no evidence of sliding scale insulin administration for elevated blood glucose for 13 of 30 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 25 of 30 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 28 of 30 days. During the month of 5/13, the 7:00 a.m. blood glucose record lacked evidence of sliding scale insulin administration for elevated blood glucose on 17 of 31 days. For the 11:00 a.m. there was no documentation of sliding scale insulin administration for elevated blood glucose for 17 of 31 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 18 of 31 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 20 of 31 days. During the month of 6/13, R48 was hospitalized for seven days. For the 7:00 a.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 14 of 23 days. For the 11:00 a.m. there was	F 428	4. Reoccurrence will be prevented by: a. Visual audits of e-MAR's for residents receiving sliding scale insulin will be completed 2 X weekly on different Units X 90 days to assure the amount given is documented. The Consultant Pharmacist will be educated on reviewing long term medication to assure indications for use are current. An audit of all monthly Pharmacist reviews will be conducted for 90 days as well to assure medications such as Pepcid have indications for use if given over a longer period of time. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Consultant Pharmacist.	

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F 428	Continued From page 30 no documentation of sliding scale insulin administration for elevated blood glucose for 17 of 23 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 17 of 23 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 18 of 23 days. During this month R48 was hospitalized for seven days. From 7/1/13, through 7/17/13, for the 7:00 a.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 4 of 17 days. For the 11:00 a.m. there was no documentation of sliding scale insulin administration for elevated blood glucose for 6 of 17 days. For the 5:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 11 of 16 days. For the 8:00 p.m. blood glucose, there was no documentation of sliding scale insulin administration for elevated blood glucose for 11 of 16 days. The registered nurse (RN)-C, interviewed on 7/18/13, at 12:50 p.m., stated that all sliding scale insulin should be documented on the EMAR. RN-C stated the amount was not recorded because, "You have to click a few more boxes and physically enter the amount..." On 7/18/13, at 1:07 p.m. the director of nursing (DON) verified that the sliding scale insulin was not documented. The DON stated that in was a medication error if not documented.	F 428		

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F 428	Continued From page 31 The facility's (undated) Preparation and General Guidelines policy indicated the individual who administers the medication dose records the administration on the resident's EMAR directly after the medications given. In no case should the individual who administered the medications report off duty without first recording the administration of medications. The consultant pharmacist (CP) was interviewed on 7/18/13, at 1:55 p.m. and stated that when any medication administration is not documented, "It's an omitted dose. Should be recorded somewhere." The CP stated he did not notice the insulin was not documented. R23 received famotidine (Pepcid) 20 milligrams (mg) every evening (reduces stomach acid) since 6/10/2010, with no documentation from the physician of indications for continued use of the medication. R23's diagnosis included history of a peptic ulcer. The quarterly Minimum Data Set (MDS) dated 4/24/13, indicated R23 had no cognitive impairment. The MDS did not identify R23 had any gastrointestinal diagnoses. A Discharge Summary dated 6/10/10, indicated R23 was admitted to the facility with physician's orders for Pepcid 20 mg daily. The current physician's orders dated 7/1/13, directed Pepcid	F 428		

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F 428	Continued From page 32 20 mg at bedtime every day for peptic ulcer. The Medication Administration Records for June and July 2013, indicated R23 received the medication every evening at 8:00 p.m. A nurse practitioner note dated 5/6/13, indicated R23 had been refusing her medications and complaining of upset stomach and nausea. R23 was on the Pepcid. R23 denied any abdominal pain, heartburn, or reflux symptoms. It was noted R23 had a recent increase in dose of another medication (Aricept - for dementia), and it was felt the gastrointestinal upset and nausea was likely related to the recent increase in dose so the Aricept was discontinued. The medical records lacked evidence R23 had any other gastrointestinal symptoms, and there was no documentation from the physician for clinical indications for continued use of the medication. On 7/18/13, at 2:00 p.m. the RN manager (RN)-D confirmed the medical records lacked documentation from the physician for the continued use of the medication. Review of the CP Monthly Medication Regimen Reviews from 7/12/11, to 7/15/13, indicated no recommendations were made regarding the Pepcid. On 7/18/13, at 1:55 p.m. the CP stated he would expect to see a diagnosis of gastroesophageal reflux disease (GERD) for long term use of the Pepcid, and must have missed it. The CP confirmed he had not made any	F 428		

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F 428	Continued From page 33 recommendations to the facility regarding the Pepcid.	F 428		

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K 000	INITIAL COMMENTS Surveyor: 03006 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Evergreen Terrace 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 Or by e-mail to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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.	K 000		

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

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

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Evergreen Terrace is a 1-story building with a partial basement and was constructed at 4 different times. The original building was constructed in 1963, is 1 story with a partial basement, and was determined to be of Type II(111) construction. In 1968 a one story addition, without a basement, was constructed south and west of the original building, and was determined to be of Type II (111) construction. In 1980 a one story addition was constructed to the north of the original building, was determined to be a type V (111) construction, and is separated with a 2-hour fire barrier. This building is no longer used by residents and is staff only. In 2001 two other one story additions were built, one north of the west wing (a chapel) and one south of the west wing (special cares unit) which were determined to be Type II (111) construction and separated with 2-hour fire barriers. The building is divided into 8 smoke zones by 30-minute and 2-hour fire barriers. The facility is fully sprinkler protected installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridor system and in all sleeping rooms installed in accordance with NFPA 72 "The National Fire Alarm Code 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 109 beds and had a	K 000		

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K 000	Continued From page 2 census of 83 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000		