### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 2BBI

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

	PART I	- TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00299
MEDICARE/MEDICAID PROVIDE     (L1)		3. NAME AND AI (L3) EVERGREF (L4) 2801 SOUTI (L5) GRAND RA	EN TERRACE H HIGHWAY 1		(L6) <b>55744</b>	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY 09 ESRD	<u>O2</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint
6. DATE OF SURVEY October 24, 20 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	109 (L18) 109 (L17)	Compliar1.  B. Not in Co		ram	And/Or Approved Waivers Of TI 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code  * Code:  B	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF	WN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
109 (L37) (L38)	(L39)	(L42)	(L43)		1001 (d) (d) 22 1001 (d) (d)	
16. STATE SURVEY AGENCY REMARKS	ARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	):		
17. SURVEYOR SIGNATURE  Kathie Killoran, HF	E NEII 10/2	Date : 24/2013		(L19)	18. STATE SURVEY AGENCY A	APPROVAL Date: ogram Specialist 01/17/2014 (L20)
]	PART II - TO BE	COMPLETED	BY HCFA R		L OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBILE  _X	Participate		MPLIANCE WITH GHTS ACT:	CIVIL	21. 1. Statement of Finat 2. Ownership/Contro 3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1987	23. LTC AGREEM BEGINNING		24. LTC AGREEM		26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41)  27. ALTERNATI  A. Suspension  B. Rescind Sus	of Admissions:	(L25)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	** - ** ** ****************************
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		
	(L32)	09/17/2013		(L33)	DETERMINATION APPR	OVAL

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: 2BBI Facility ID: 00299

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.

FORM CMS-1539 (7-84) (Destroy Prior Editions)



#### 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 folliwing 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

Evergreen Terrace November 12, 2013 Page 2

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 Evergreen Terrace November 12, 2013 Page 3

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.

Evergreen Terrace November 12, 2013 Page 4

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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.

5495r1\_13.rtf

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
Telephores (651) 201, 4118 Few (651)

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

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

#### Health PCR

Form Approved OMB NO. 0938-0390

#### Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245495	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/24/2013
Name	of Facility		Street Address, City, State, Zip Code	
ΕV	ERGREEN 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 Reg. # LSC	F0157 483.10(b)(11)		Correction Completed 08/27/2013		ID Prefix Reg. # LSC	F0278 483.20(g) - (j)		Correction Completed 08/27/2013		ID Prefix Reg. # LSC	483.25(d)		Correction Completed 08/27/2013
•	F0329 483.25(I)		Correction Completed 08/27/2013		ID Prefix Reg. # LSC	F0333 483.25(m)(2)		Correction Completed 08/27/2013			F0334 483.25(n)		Correction Completed 08/27/2013
ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 08/27/2013		Reg.#			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC													Correction Completed
ID Prefix Reg. # LSC			-		Reg. #								
Reviewed By State Agency		Reviewed I	=	Da 11	te: /12/20	Signature of	Surve	yor: 296:	25			Date: 10/24	/2013
Reviewed By		Reviewed I	Ву	Da	te:	Signature of	Surve	yor:				Date:	
Followup to	Survey Comple						-				a Summary of to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

#### Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245495	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/24/2013
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EVERGREEN TERRACE		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	

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(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y	) Item	(	(Y5)	Date
			Correction					Correction					Correction
ID D	50405		Completed		ID D . C	<b>500.40</b>		Completed		ID D . *	F00=0		Completed
ID Prefix	F0167		10/11/2013		ID Prefix			10/11/2013		ID Prefix			10/11/2013
•	483.10(g)(1)				•	483.15(f)(1)				•	483.20(d), 483.2		_
LSC					LSC				_	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0282		10/11/2013		ID Prefix	F0334		10/11/2013		ID Prefix	F0428		11/11/2020
Reg. #	483.20(k)(3)(ii)				Reg.#	483.25(n)				Reg. #	483.60(c)		
LSC					LSC			•		LSC			_
			Correction					Correction					Correction
ID Prefix	E0/31		Completed 10/11/2013		ID Prefix	E0465		Completed 10/11/2013		ID Prefix	E0467		Completed <b>10/11/2013</b>
			10/11/2013					. 10/11/2013			-		10/11/2013
•	483.60(b), (d), (e)				Reg. # LSC	483.70(h)				•	483.70(h)(2)		_
				_					+				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC			•		LSC			<del>-</del>
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
								-					_
Reg. # LSC					Reg. # LSC			-		Reg. #			_
									+				_
Reviewed By	Revie	ewed E	Зу	Dat	te:	Signature of	Surve	yor:				Date:	
State Agency	, M	M/P	H	11	/12/20	-		625				10/24	1/2013
Reviewed By	Revie	ewed E	Зу	Dat	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed o	n:				Check f	or any	Uncorrected	Defi	ciencies. Was	a Summary of	1	
	8/29/2013					Unco	orrecte	d Deficiencies	s (Cl	/IS-2567) Sent	to the Facility?	YES	NO

11-	14-'13 17:15 FR	OM- Evergreen Terrace	218-32	27-3217 T-170 P0013/0017	F-063
		AND HUMAN SERVICES  & MEDICAID SERVICES	Fed	aral tourit OMBNO	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	ОТ 3/1 сом	ESURVEY PLETED R FOOL
		245495	B. WING		24/2013
NAME OF P	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE	
EVERGR	EEN TERRACE		-	GRAND RAPIDS, MN 55744	<u>, , , , , , , , , , , , , , , , , , , </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	тѕ	{F 000}	F241	11-22-13
{F 241} SS=D	The facility must promanner and in an elenhances each res	AND RESPECT OF  romote care for residents in a environment that maintains or ident's dignity and respect in his or her individuality.	{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.	
	by: Based on observa failed to provide ar	NT is not met as evidenced and interview, the facility and adequate cover up for y following a shower for 1 of 4 viewed for dignity.		<ol> <li>Corrective Action as it applies to other residents:</li> <li>a. The Policy and Procedure for dignity, which includes warmth with shower/bath was reviewed and revised.</li> <li>b. An Inservice on dignity, to include covering after shower/bath, was held on 11/5 and 11/6/13.</li> </ol>	
	disease, allergic ridiabetes type 2, es osteoarthrosis, hyphypertension, and R42's quarterly midated 10/3/13, indintact, was totally required extensive personal hygiene a help in part of bath R42's care plan rerequired a hoyer li	perlipidemia, hemiplegia, venous insufficiency.  nimum data set (MDS) review icated R42 was cognitively dependent in transferring, and activities, and required physical		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.	
١.		DER SUPPLIER REPRESENTATIVE'S SIG	NATURE	administrator	(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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DTKC12

Facility ID: 00299

If continuation sheet Page 1 of 5

218-327-3217

T-170 P0014/0017 F-063

FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	<u>0938-0391</u>
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPL NG	LE CONSTRUCTION	(X3) DATE	SURVEY
		245495	B. WING			10/2	R 24/2013
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
{F 241}	seated in wheeled of community show the 400 wing of the assistants (NA's) (observed to be bus areas of R42's thig white bath towels cand lap areas. R4 wet and plastered verbalized how cold 2 NA's was heard town the hallway town and a membiseated in a wheeled	shower chair being pushed out ver room and into hallway of a facility. Two nursing NA-A and NA-F) were sily trying to cover exposed hs and abdominal sides with draped around R42's midriff 2's hair was observed to be to [his/her] head. R42 d the hallway felt. One of the co state as they wheeled R42 oward R42's room, which was own the hall from the shower er of the opposite sex was hair near R42's room doorway, ant's first name], you still have		41}			
	not helping R42 will aware R42's family towel to use on shi R42's closet and retowel. NA-E further kept in the shower access to bath bla printed fabric pond	30 p.m. NA-E stated she was th a shower yesterday but was y had brought in a large bath ower days. NA-E went into etrieved a large, white bath er stated bath linens are not room but the NA's have nkets and large, oversized chos to cover residents during wer room to their own room for					
	assisted R42 with been aware R42 wexit from the show down to R42's roo the large, white ba	00 p.m. NA-A stated she had a shower on 10/22/13, and had was not totally covered upon wer room, into the hallway, and m. NA-A confirmed R42 had ath towel over [his/her] and have had something more					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DTKC12

Facility ID: 00299

If continuation sheet Page 2 of 5

DEPART	MENT OF HEALTH	)M- Evergreen Terrace AND HUMAN SERVICES & MEDICAID SERVICES	218-327-3217 T-170 P0015/0017 F-063 FORM APPROVE OMB NO. 0938-03								
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION			IE SURVEY MPLETED				
		245495	B. WING			10	R /24/2013				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 2801 SOUTH HIGHWAY		DE					
EVERGR	EEN TERRACE			GRAND RAPIDS, MN							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN		HOULD BE	(X5) COMPLETION DATE				
{F 241}	exposed.  On 10/23/13, at 3:2 always very uncomof the shower room. Inis/her] own room. hallway is cold and wet sling. R42 wer under those covers being wheeled down and just does not lited. On 10/24/13, at 11: (RN)-C stated R42 showering and showering the shower	ides and lap, as to not be so 25 p.m. R42 stated [he/she] is ifortable when transported out and down the hallway to R42 further stated the [he/she] is seated on a cold, it on to state [he/she] is naked and feels cold and exposed in the hall to [his/her] room ke it at all.  30 a.m. registered nurse should not be cold after uld be covered up when room. RN-C confirmed those	{F 241}								
F 312 SS=D	A Shower/Tub Bath indicated staff show appropriately cover not be exposed and when being transport area in a bath chair 483.25(a)(3) ADL COEPENDENT RESEATE A resident who is undaily living receive	CARE PROVIDED FOR	F 312	2							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DTKC12

Facility ID: 00299

If continuation sheet Page 3 of 5

This REQUIREMENT is not met as evidenced

Based on observation, interview, and document

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Ol	1	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		SURVEY
		245495	B. WING			1	₹ 24/2013
	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	review, the facility removed for 1 of 1 activities of daily lir Findings include: R4's diagnoses includes and the findings include: R4's diagnoses includes and the first and hyperterinsufficiency, congosteoporosis, cereinfarct, and hyperterinfarct, and hyperterinfarct	failed to ensure facial hair was residents (R4) reviewed for ving (ADL's).  Iluded ventilator dependence, weakness, esophageal reflux, mia, mitral stenosis with estive heart failure, bral artery occlusion with ension.  Imum data set (MDS) review ated R4 had short term and required extensive resonal hygiene activities.  Or hygiene/ADL's/skin lacked an intervention to I hair removal.  Guide (nursing assistant's care acked information to address a needs for facial hair removal.  O1 a.m. R4 was observed chair in [his/her] room, awaiting a noted to have many long, wher] chin.  46 a.m. R4 was observed air in [his/her] room, awaiting a noted to have an orange hat and also had many long, white		312	1. Corrective Action: a. Resident # 4 chin hair was removed as soon as the concern was identified. This resident ha certain preferences for caregive and often displays behaviors which are troubling for her if he preferences are not honored. H. 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 it she will allow and to document 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 include shaving, was reviewed and remains current. b. All Resident's Care Plans a NAR Care Sheets will be	s rs rr er f if h	11-22-13

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DTKC12

Facility ID: 00299

If continuation sheet Page 4 of 5

T-170 P0017/0017 F-063

FORM APPROVED

OMB NO. 0938-0391

	CENTER	(2 FOR MEDICARE	A MEDICAID SERVICES				1101	0000 000.
NAME OF PROVIDER OR SUPPLIER  EVERGREEN TERRACE    SUMMARY STATEMENT OF DEFICIENCIES   2391 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744				` '				
EVERGREEN TERRACE    X40 ID   SUMMARY STATEMENT OF DEFICIENCIES   GRAND RAPIDS, MN 55744			245495	B. WING			1	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 312  Continued From page 4 aware of the chin hairs and further stated "Angle takes care of them." R4 reported [he/she] receives a bath on Fridays when the chin hairs are shaved by "Angle."  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 "Angle" 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 growing in the case included facial hair care.			243433		S7 28	801 SOUTH HIGHWAY 169	10/2	14/2013
aware of the chin hairs and further stated "Angle takes care of them." R4 reported [he/she] receives a bath on Fridays when the chin hairs are shaved by "Angle."  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 "Angle" 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 growning appeals included facial hair care.	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
	F 312	aware of the chin hakes care of them receives a bath on are shaved by "And On 10/24/13, at apacting director of novery particular about provides which per assistance for [him surveyor entered FR4's long white chip permission from Rawhich R4 granted to confirmed R4's long have been remove probably about 2 working or not last nursing assistant spermission to remove A Resident Dignity directed each residence otherwise indicated	rairs and further stated "Angie". R4 reported [he/she] Fridays when the chin hairs gie."  proximately 10:45 a.m. the ursing (ADON) stated R4 is ut which nursing assistant sonal cares and grooming l/her]. The ADON and the R4's room. The ADON noted in hairs and requested to trim or shave the hairs to the ADON. The ADON g, white chin hairs should ad prior to this date and were weeks growth. The ADON was unsure if "Angie" was Friday, however another hould have requested ove the hairs.  with Cares policy [undated], dent who needs assistance with ive this assistance, unless d. The policy further directed		312	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	f	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:DTKC12

Facility ID: 00299

If continuation sheet Page 5 of 5

218-327-3217

T-170 P0002/0017 F-063

FORM APPROVED

<u>OMB NO. 0938-0391</u>

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		DATE SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG_	- NE (1)	COMPLETED
					0, 18,1	R
		245495	B, WING		1,00,	10/24/2013
NAME OF F	ROVIDER OR SUPPLIER	A ACTIVITY OF THE PARTY OF THE		\$1	FREET ADDRESS, CITY, STATE, ZIP CODE	
				28	801 SOUTH HIGHWAY 169	
EVERGR	EEN TERRACÉ			G	RAND RAPIDS, MN 55744	
	CLIMANADY STA	TEMENT OF DEFICIENCIES	ID	<b>_</b>	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	'IX	(EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	ì	CROSS-REFERENCED TO THE APPROPRIAT( DEFICIENCY)	E DAIL
					DEI ICIENOT)	
{F 000}	INITIAL COMMEN	TS	{F 0	00)	F282	11 27-12
				.		11-22-13
	A follow-up survey	was completed for			1. Corrective Action:	
		to Complaint #H5495034.			<ol> <li>Upon interview, the nursing</li> </ol>	ei ()
	F157 was correcte				assistant assigned to Resident #	
{F 282}		RVICES BY QUALIFIED	{F 2	2823	179 (same resident as #164)	
₹Γ 202} SS=D	PERSONS/PER C		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	<sub>-</sub>	stated she had repositioned him	
33-D	i Litopiao/i Lito				at 0645 on 10/23/13 according	
	The services provi	ded or arranged by the facility			to his care plan, but had not had	
	must be provided l	by qualified persons in			a chance to document the	
	accordance with ea	ach resident's written plan of			repositioning time on the Flow	
	care.	and the state of t			Sheet at the nurses station due	
•					to the busy morning. She had	
					documented the time on a paper	
	This REQUIREME	NT is not met as evidenced			towel from the resident's room	1
	by:				and placed it in her pocket so	
		ation, interview, and document			she would have the correct time	
		failed to offer repositioning as			when she later documented on	
		n of care for 1 of 3 residents			the Flow Sheet. She stated the	
		or pressure ulcers.			resident then turned on his call	
			1		light at around 0725 and stated	
		,	1	U .,	he had "shoulder pain" so she	
	Findings include:	<b>\</b>			then moved a pillow under his shoulder to provide comfort.	
					At 0845 she stated she and the	
					nurse repositioned the resident	
		ed on 7/9/13, with diagnoses			and wound care was provided.	
	, -	Iriplegia, stage 4 pressure			The resident often sits at an	
	ulcer, chronic pain	i, and esophageal reflux.			angle in bed higher than 30	
					degrees and in warmer weather	
					spends much time outside in his	
		nimum Data Set (MDS) dated			electric wheelchair. He has	
	1	R164 was cognitively intact,			been explained the risk/benefit	
7		dent for bed mobility and			of refusal to allow pressure	
		at risk for pressure ulcer			relief off his coccyx while in	
1		e MDS identified R164 had 2			both chair and bed, and is	
		ulcers and 1 Stage 4 pressure			reminded of these risks/benefits	
		a pressure-reducing device on a turning and repositioning			no less than quarterly at his care	
		as nutrition or hydration			conferences.	
	1. •		<u> </u>			
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

T-170 P0003/0017 F-063

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	245495	B. WING_		10/24/2013	
NAME OF PROVIDER OR SUPPLIER EVERGREEN TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
and Risk Factors date had a stage 4 sacral cm in length by 4 cm.  The care plan revises mechanical lift and 2 physical assistance of in bed every two hour assistant care guide use of a hoyer lift for pressure ulcer, and we to side in bed every?  Continuous observat 10/2313, from 7:15 at a.m At 7:18 a.m at 7:18 a.m at 7:18 a.m at entered R164's room acting director of nur room when the techn approximately 7:20 at sitting up in bed with elevated to approximate. The area of the end of the degrees. At 7:33 a.m. entered the room starepo!" NA-B lowered from the left side, us underneath R164 to placing a flat pillow to the end of the placing a flat pillow to placing a flat pillow to the end of the placing a flat pillow to placing a fla	valuation of Skin Inspection ed 7/31/13, indicated R164 pressure ulcer measuring 3 in in width by 5 cm in depth.  d 8/27/13, directed a staff for transfers and of 1-2 staff for repositioning ins. An undated nursing indicated R164 required the fall transfers, had a sacral was to be repositioned side 2 hours.  dions were completed on a.m. to approximately 9:20 2 laboratory technicians in for a blood draw. The raing (ADON) entered the nicians finished at a.m R164 was observed	{F 28	2 Corrective Action as it applie	and g and e a the	

FORM CMS-2567(02-99) Previous Varsions Obsolete

Event ID:2BBI12

Facility ID: 00299

If continuation sheet Page 2 of 11

218-327-3217

T-170 P0004/0017 F-063

FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			ON		<u>0938-0391</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245495	B. WING				R 10/24/2013	
NAME OF P	ROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE			
EVERGR	VERGREEN TERRACE				801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 282}	sitting up in bed wirulcer until wound ca.m  On 10/24/13, at 10 (RN)-D stated R16 repositioned side to person assistance sacral pressure ulcorepositioning of R1 as a reposition for R164's shoulder di	legrees. R164 remained th full pressure on the sacral are was observed at 9:00  :45 a.m. registered nurse 4 should be turned and 5 side every 2 hours with 2 to prevent pressure on the eer. RN-D confirmed the 64's shoulders did not count R164, as it provided relief for scomfort but did not constitute activity for R164's stage 4	{F 2	82}	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 Q Committee for input on the new to increase, decrease, or discontinue the audits.  4. The Correction will be monitored by: DON/ Nurse Managers/Designee	A		
{F 314} SS=D	had been informed pressure on the staconfirmed R164 w not repositioned si by the plan of care 483.25(c) TREATA PREVENT/HEAL I Based on the comresident, the facilit who enters the fact does not develop individual's clinical they were unavoid pressure sores receivices to promote		{F 3	314}	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 ha not documented the repositionin time on the Flow Sheet located at the Nurses' Station, but rather of 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.	t d g n	i1-22-13	

218-327-3217

T-170 P0005/0017 F-063

FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY PLETED
		245495	B. WING		<u> </u>	l .	⋜ 24/2013
NAME OF F	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	REEN TERRACE				2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIÊNCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	This REQUIREME by: Based on observa review, the facility repositioning for propersity and pressure ulcers for reviewed for press Findings include:  R164's was admitted that included quadrulcer, chronic pain  The Admission Mir 7/22/13, indicated was totally dependent and evelopment. The Stage 2 pressure of the bed and chair,	NT is not met as evidenced tion, interview, and document failed to encourage ressure relief related to 1 of 3 residents (R164)	{F 3	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. A 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.	n S L L L L L L	
	and Risk Factors of was chairfast, at ran existing pressumobility and activitindicated R164 has assistance with activities and psychotropic devices in place,	Evaluation of Skin Inspection dated 7/31/13, indicated R164 isk for shear and friction, had are ulcer, and scored low in ity. The evaluation further ad fragile skin, required ctivities of daily living (ADL's), drug use, and had medical all of which contributed to ilcer risk. The evaluation			<ul> <li>d. Every nurse who works at Evergreen Terrace will have a visual return demonstration of wound care with dressing chang to assure proper technique is performed.</li> <li>3. Date of Completion: 11/22/13</li> </ul>		

FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID:2BBI12

Facility ID: 00299

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218-327-3217

T-170 P0006/0017 F-063

FORM APPROVED OMB NO. 0938-0391

CENTER	& MEDICAID SERVICES					<u>0938-0391</u>	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  R 10/24/2013	
		245495	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	ERGREEN TERRACE				801 SOUTH HIGHWAY 169 BRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	ulcer measuring 3 by 5 cm in depth.  The care plan reviewed and the control of th	a stage 4 sacral pressure cm in length by 4 cm in width sed 8/27/13, directed 2 staff for transfers and e of 1-2 staff for repositioning	{F 3	14}	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		
	beginning of obse a.m. At 7:18 a.m. knocked on R164' for a blood draw. (ADON) was roun entered the room at approximately sitting up in bed welevated to approximately of the room at approximately sitting up in bed welevated to approximately	loor was closed at the rvation on 10/23/13, at 7:15 2 laboratory technicians s door and entered the room. The acting director of nursing ding with the technicians and when the technicians finished 7:20 a.m., R164 was observed with the head of the bed eximately 75 degrees. The yed to offer R164 a drink of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:2BBI12

Facility ID: 00299

If continuation sheet Page 5 of 11

218-327-3217

T-170 P0007/0017 F-063

FORM APPROVED
MR NO 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				IVID NO.	<u> </u>	
\$TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245495	B. WING			I.	₹ 24/2013	
		240430			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/2	4/2013	
NAME OF P	PROVIDER OR SUPPLIER		ſ		,			
FVFRGR	EEN TERRACE				2801 SOUTH HIGHWAY 169	•		
	LICOTURAL FRANCES			1	GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU				BE	(X5) COMPLETION DATE
{F 314}	heard to ask the ro a.m. R164 activate practical nurse (LP room at 7:29 a.m. I more water and for raised a little more the bed to approxin R164 with a drink of 7:30 a.m R164 we pressure on the sanursing assistant (R164's room statin NA-B lowered the left side, used a sn R164 to pull [him/h flat pillow under R164 raised the head of approximately 75 of	he television. R164 was om door be left open. At 7:27 ed the call light and licensed N)-B knocked and entered the R164 was heard to ask for the head of the bed to be. LPN-B raised the head of mately 90 degrees, provided of water, and left the room at as sitting up in bed with full cral area. At 7:33 a.m. NA)-B knocked and entered g, "It's time for a little repo!" head of the bed and, from the nall turning sheet underneath her] towards NA-B, placing a 164's right shoulder. NA-B the bed back up to degrees, turned off the radio	{F 3	14]	<b>}</b>			
	on 10/23/13, at 9:1 observed to knock LPN-B washed her sink and donned dapplied disposable onto the right hip. dressing and woun gloves, applied hadonned a new pair normal saline into coccyx area, using solution and bright LPN-B applied pre	t, and exited the room at a.m.  Do a.m. LPN-B and NA-C were and enter R164's room. Thands in R164's bathroom isposable gloves. NA-C gloves and assisted R164 LPN-B removed the old ad packing, removed the soiled and sanitizer to her hands, and of gloves. LPN-B sprayed the open ulcer on R164's gauze dressings to catch the red drainage from the ulcer. ssure to the ulcer, soaking up changing the saturated gauze						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:288112

Facility ID: 00299

If continuation sheet Page 6 of 11

several times. LPN-B removed soiled gloves

DEPART	MENT OF HEALTH	)M- Evergreen Terrace AND HUMAN SERVICES & MEDICAID SERVICES	218-	327-3217		/0017 F-0 FORM APP <b>//B NO. 093</b>	ROVED
STATEMENT (	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY
		245495	B. WING _			10/24/2	013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
EVERGREEN TERRACE				2801 SOUTH HIGHWAY 16 GRAND RAPIDS, MN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPI FICIENCY)	BE CO	(X5) MPLETION DATE
	to R164's bedside of applied normal salidressing, and using packed the sacral of covered the ulcer of taped into place. Lincontinent pad to positioned R164 or On 10/24/13, at 10 (RN)-D stated R16 repositioned side to person assistance sacral pressure ulcorepositioning of R1 as a reposition for R164's shoulder di	with soap and water, returning with clean gloves. LPN-B ne spray solution to gauze g a cotton-tipped applicator, alcer with gauze. LPN-B with 2 thick gauze dressings PN-B and NA-C applied an hold the dressing in place and a the back.  :45 a.m. registered nurse 4 should be turned and a side every 2 hours with 2 to prevent pressure on the err. RN-D confirmed the 64's shoulders did not count R164, as it provided relief for scomfort but did not constitute activity for R164's stage 4	{F 314				
	had been informed pressure on the sta confirmed R164 wa	13 p.m. the ADON stated R164 of the risks of prolonged age 4 coccyx ulcer. The ADON as positioned on the back and de to side in bed as directed .					
F 441 SS=D	and revised 8/09, of treatment to Stage affected area.	re ulcer care policy reviewed directed for pressure ulcers 3 or 4, to position resident off N CONTROL, PREVENT	F 44	<b>1</b> 1			
	The facility must e	stablish and maintain an					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:28BI12

Facility ID: 00299

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T-170 P0009/0017 F-063

FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OI	MB NO.	<u>0938-0391                                    </u>
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION (X3) DATE S COMPL		SURVEY
		245495	B. WING			R 10/24/2013	
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2 G	TREET ADDRESS, CITY, STATE, ZIP CODE  801 SOUTH HIGHWAY 169  FRAND RAPIDS, MN 55744  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	B€	(X5) COMPLETION DATE
F 441	safe, sanitary and to help prevent the transmission of dis  (a) Infection Contro The facility must exprogram under wh (1) Investigates, coin the facility; (2) Decides what personal be applied to actions related to in  (b) Preventing Spr. (1) When the Infect determines that a prevent the spreadisolate the residen (2) The facility must communicable disfrom direct contact will to the facility must hands after each contact will to the facility must hand after each contact will to the facility must hand after each contact will to the facility must hand after each contact will to the facility must hand after each contact will to the facility must hand after each contact will to the facility must hand after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must have been some after each contact will to the facility must be after the facility must b	rogram designed to provide a comfortable environment and development and ease and infection.  Of Program stablish an Infection Control ich it - controls, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections.  The ead of Infection control Program resident needs isolation to do fin fection, the facility must the stable prohibit employees with a ease or infected skin lesions the with residents or their food, if transmit the disease.  St require staff to wash their direct resident contact for which indicated by accepted		141	1. Corrective Action: a. LPN# A that did not follow the proper handwashing/gloving procedure when completing dressing changes was reeducated 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	Ţ	11-22-13

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI12

Facility ID: 00299

If continuation sheet Page 8 of 11

T-170 P0010/0017 F-063

FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			ON	<u> 18 NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•		245495	B. WING	·	<u> </u>	F 10/2	₹ 24/2013
	ROVIDER OR SUPPLIER	J		;	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	review, the facility hygiene during dre resident (R43, R92). Findings include:  On 10/23/13, at 3 nurse (LPN)-A was change to a pressu LPN-A was not obtained prior to enteremoved R43's so donned gloves to cleansed the wour applied Vaseline to tipped applicator, dated the new foal backing from the foam dressing to to clean gloves, applitouched the stump blue heel boot to blanket. LPN-A redoor with the hand the hallway. At 3:3 not aware of the rebefore applying cl soiled dressings, a room.	age 8  ation, interview and document failed to utilize proper hand assing changes for 2 of 3  2) observed for wound care.  215 p.m. licensed practical sobserved doing a dressing ure ulcer on R43's right ankle. Served to wash or sanitize her ering R43's room. LPN-A ck and, without handwashing, remove the old dressing, and with normal saline, and o wound edges with a cotton LPN-A removed the gloves, removed the foam dressing and applied the he wound. LPN-A donned lied R43's sock, looked at and o on the other leg, applied a R43's foot and pulled up the moved the gloves, opened the dle, and used hand sanitizer in 30 p.m., LPN-A stated she was equirement to wash hands ean gloves, after removing and before exiting the resident's (RN)-B was observed, on		441	4. Reoccurrence will be prevented by: a. Visual audits will be conducted 2x weekly on all Unit x90 days on nurses completing dressing changes to assure prope 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		
i	10/24/13, at 10:30 change to a woun	(RN)-B was observed, on 0 a.m., during a dressing d on R92's right foot. RN-A rom the bathroom, set up area					
			^		Estable (D. 00000	uction abo	at Dags C of 1:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; 2BBI12

Facility ID: 00299

If continuation sheet Page 9 of 11

T-170 P0011/0017 F-063

DEPARTMENT OF HEALTH	AND HUMAN SERVICES		FORM APPROVE
CENTERS FOR MEDICARE	& MEDICAID SERVICES	C	<u>MB NO. 0938-039</u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
		<del></del>	R
	245495	B. WING	10/24/2013
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
		2801 SOUTH HIGHWAY 169	

EVERGR	EEN 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)	(X\$) 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."	F 441				
,	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					
RM CMS-2	567(02-99) Previous Versions Obsolete Event ID: 2BBI12	Facil	lity ID: 00299 If continuation she	et Page 10 of		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI12

Facility ID: 00299

If continuation sheet Page 10 of 11

218-327-3217

T-170 P0012/0017 F-063

FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	COM	E SURVÉY IPLETED	
		245495	B. WING			R /24/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE ACTIO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	The facility Dressir (not dated) directed put on clean glove dressing then wash clean dressing tour Put on clean glove	ean, between glove changes, d exiting the resident's room.  In Changes (Dry,Clean) policy d staff to wash and dry hands, is and remove the soiled in and dry hands, open dry, ching the exterior surface only. Its clean wound, apply the land secure, remove gloves and		441			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI12

Facility ID: 00299

If continuation sheet Page 11 of 11

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 2BBI

Facility ID: 00299

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

1. MEDICARE/MEDICAID PROVIDER (L1) 245495 2.STATE VENDOR OR MEDICAID NO. (L2) 606318700	NO.	3. NAME AND ADDRESS OF FACILITY (L3) EVERGREEN TERRACE (L4) 2801 SOUTH HIGHWAY 169 (L5) GRAND RAPIDS, MN (L6) 55744			L6) <b>55744</b>	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP	PPLIER CATEGOR	Y 09 ESRD	_ <u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint	
6. DATE OF SURVEY 07/18/2 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE	FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds  14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  109	109 (L18) 109 (L17) N 19 SNF	Complianc1. A1. B. Not in Com			2345. * Code:	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code  **B***	e Following Requirements:	
(L37) (L38)  16. STATE SURVEY AGENCY REMAR	(L39) KS (IF APPLICABL	(L42) E SHOW LTC CANCE	(L43) LLATION DATE):					
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE	E SURVEY AGENCY A	PPROVAL Date:	
	NEII		08/13/2013	(L19)			(L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	L OFFICE	OR SINGLE STA	ATE AGENCY	
DETERMINATION OF ELIGIBILITY			PLIANCE WITH C GHTS ACT:	CIVIL	21.	2. Ownership/Control	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)	
	(L21)					3. Both of the Above :		
22. ORIGINAL DATE	(L21) 23. LTC AGREEM	ENT 24	. LTC AGREEME	ENT	26. TERM	3. Both of the Above :	(L30)	
22. ORIGINAL DATE  OF PARTICIPATION  08/01/1987			LTC AGREEME		VOLUNTAI 01-Merger, 0	IINATION ACTION:  RY 00  Closure	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety	
OF PARTICIPATION	23. LTC AGREEM				VOLUNTAI 01-Merger, C 02-Dissatisfa	IINATION ACTION:  RY 00  Closure  action W/ Reimbursement	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety	
OF PARTICIPATION <b>08/01/1987</b>	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI	DATE	ENDING DATE (L25)		VOLUNTAI 01-Merger, O 02-Dissatisfa 03-Risk of Ir	IINATION ACTION:  RY 00  Closure	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  nt 06-Fail to Meet Agreement  OTHER  07-Provider Status Change	
OF PARTICIPATION 08/01/1987 (L24)	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI	DATE  VE SANCTIONS  n of Admissions:	(L25)		VOLUNTAI 01-Merger, O 02-Dissatisfa 03-Risk of Ir	MINATION ACTION:  RY 00  Closure  action W/ Reimbursement involuntary Termination	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  1t 06-Fail to Meet Agreement  OTHER	
OF PARTICIPATION 08/01/1987 (L24)  25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATT A. Suspension B. Rescind Sus	DATE  VE SANCTIONS  n of Admissions:  spension Date:	(L25)  (L44)  (L45)		VOLUNTAI 01-Merger, C 02-Dissatisfa 03-Risk of Ir 04-Other Rea	IINATION ACTION:  RY	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  nt 06-Fail to Meet Agreement  OTHER  07-Provider Status Change	
OF PARTICIPATION 08/01/1987 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATT A. Suspension B. Rescind Sus	VE SANCTIONS n of Admissions: spension Date:	(L25)  (L44)  (L45)		VOLUNTAI 01-Merger, O 02-Dissatisfa 03-Risk of Ir	IINATION ACTION:  RY	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  nt 06-Fail to Meet Agreement  OTHER  07-Provider Status Change	
OF PARTICIPATION 08/01/1987 (L24)  25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATT A. Suspension B. Rescind Sus	DATE  VE SANCTIONS  n of Admissions:  spension Date:	(L25)  (L44)  (L45)		VOLUNTAI 01-Merger, C 02-Dissatisfa 03-Risk of Ir 04-Other Rea	IINATION ACTION:  RY 00  Closure action W/ Reimbursement involuntary Termination ason for Withdrawal	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  nt 06-Fail to Meet Agreement  OTHER  07-Provider Status Change	
OF PARTICIPATION 08/01/1987 (L24)  25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATT A. Suspension B. Rescind Sus	VE SANCTIONS n of Admissions: spension Date:	(L25)  (L44)  (L45)  CARRIER NO.	(L31)	VOLUNTAI 01-Merger, C 02-Dissatisfa 03-Risk of Ir 04-Other Rea	IINATION ACTION:  RY 00  Closure action W/ Reimbursement involuntary Termination ason for Withdrawal	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  06-Fail to Meet Agreement  OTHER  07-Provider Status Change  00-Active	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: 2BBI Facility ID: 00299

**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.



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;

Evergreen Terrace July 31, 2013 Page 2

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

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

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

#### DEPARTMENT CONTACT

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

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.

Evergreen Terrace July 31, 2013 Page 4

#### 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

Evergreen Terrace
July 31, 2013
Page 5
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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Evergreen Terrace July 31, 2013 Page 6

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Colleen Feach

PO Box 64900 Saint Paul, Minnesota 55164-0900

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

Enclosure

cc: Licensing and Certification File

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

218-327-3217

T-207 P0002/0035 F-299

PRINTED: 07/31/2013
FORM APPROVED
MR NO DOSSIDSOL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245495	B. WING	<u> </u>	·····	07/	18/2013	
NAME OF PROVIDER OR SUPPLIER  EVERGREEN TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE  2801 SOUTH HIGHWAY 169  GRAND RAPIDS, MN 55744					
(X4) ID PREPIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREF) TAG	X CI	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	V (X6) COMPLETION DATE	
F 000	INITIAL COMMEN	гв	FO	00				
· •	WILL SERVE AS Y COMPLIANCE UP ACCEPTANCE. YO BOTTOM OF THE	AN OF CORRECTION (POC) OUR ALLEGATION OF ON THE DEPARTMENT'S OUR SIGNATURE AT THE FIRST PAGE OF THE WILL BE USED AS COMPLIANCE.			OK 8-13-13 PLN		:	
	AN ONSITE REVISE BE CONDUCTED SUBSTANTIAL COREGULATIONS H	OF AN ACCEPTABLE POC, SIT OF YOUR FACILITY MAY TO VALIDATE THAT DMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			PLH			
SS≅D	completed. The consideration in heat status in either life clinical complication significantly (i.e., a existing form of tre consequences, or a deficiency of the consequences, or a existing form of tre consequences, or a deficiency and has the properties of the clinical complication in heat status in either life clinical complication of the consequences, or a desired consequences, or a desired consequences, or a desired consequences.	ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in cotential for requiring physician if leant change in the resident's resychosocial status (i.e., a aith, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of		67	I. Corrective Action: a. Resident #94 family was notified of resident's chan in skin condition.  2. Corrective Action as it appl to other resident: a. The Policy and Procedure for family notification was review 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 was held on 8/6 & 8/7/2013 for all licensed nurse	les r ed	(X6) DATE 8/4/13	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the instillution may be excused from correcting providing it is determined that other safeguards plovide 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.

FORM CMS-2687(02-99) Previous Versions Obsolete

Event ID: 28Bit1

Facility ID: 00299

If continuation sheet Page 1 of 34

218-327-3217

T-207 P0003/0035 F-299

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FV	ZCSEVI	KLLL	(UVE	U
CIAD	NIC	0020	2000	1
OMB.	NO.	UUS	<b>コー</b> レンコヒ	, ,

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING 07/18/2013 245495 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2801 SOUTH HIGHWAY 169 EVERGREEN TERRACE** GRAND RAPIDS, MN 55744 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 F 157 | Continued From page 1 3. Date of Completion: 8/27/13 treatment); or a decision to transfer or discharge 4. Reoccurrence will be the resident from the facility as specified in prevented by: §483,12(a). a. All resident changes in condition are documented on the The facility must also promptly notify the resident 24 hour report. To assure family and, if known, the resident's legal representative notification, a space will be or interested family member when there is a added to the 24 hour report to change in room or roommate assignment as specified in §483.15(e)(2); or a change in indicate such. Daily X 90 days, residents with change in resident rights under Federal or State law or condition will be audited to regulations as specified in paragraph (b)(1) of assure family notification this section. occurred. The results of these audits will be reviewed by the The facility must record and periodically update QA Committee and input given the address and phone number of the resident's legal representative or interested family member. on the need to increase, decrease, or discontinue the audits. This REQUIREMENT is not met as evidenced 5. The Correction will be monitored by: DON/Designee 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 vicers.

ORM CM8-2667(02-99) Previous Versions Obsolete

Event ID: 288111

Facility ID: 00299

If continuation sheet Pager 2 of 34

218-327-3217

T-207 P0004/0035 F-299

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

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		07	//18/2013
	PROVIDER OR SUPPLIER		28	TREET ADDRESS, CITY, STATE, ZIP CO 801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 56744	DDE .	710/2013
(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 COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ACTION OF TH	(XS) COMPLETION DATE	
F 157	Continued From pa	age 2	F 157			
	indicated R94 had assessment (CAA) assistance with be the development opressure ulcer CAV received extensive reposition R94 whe assistance of 1 stawhen R94 was upulcer CAA also not issues along with rhours by staff, had on the bed and a puthe wheelchair. Thindicated staff were with cares and R94 licensed staff weel and capt and capt and capt and capt and R94 licensed staff weel and capt and c	ress note dated 2/16/13, a pressure ulcer care area related to R94 needing d mobility and was at risk for f pressure ulcers. The A further indicated R94 assistance of 1 to 2 staff to en in bed and extensive ff to off-load [relieve pressure] in a wheelchair. The pressure ed R94 had no current skin epositioning required every 2 a pressure reducing mattress ressure reducing cushion in the pressure ulcer CAA further to observe R94's skin daily the skin was to be inspected by a skin was to be inspected by the with a shower/bath.				
•	7/6/13, indicated R the right buttock ar right sacrum and ri	ocumentation form dated 94 had both an abrasion on ea and boil-like lesions on the ght gluteal fold areas with be soant in amount, type.				
		ess note dated 7/8/13,				

)RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 28BI11

Facility ID: 00299

If continuation sheet Page 3 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

218-327-3217

T-219 P0002/0009 F-321

PRINTED: 07/3

RECEIVED

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 1 2 2013			SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER	245495	B, WING	MN Dept of Health Duteth STREET ADDRESS, CITY, STATE, ZIP CODE	07/1	8/2013
EVERGREEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE	(X6) COMPLETION DATE
On 7/18/13, at 4:30 (DON) was intervised and physician shound 7/6/13, of the charter DON confirms progress note could notification had occurred and revised 3/2013 integrity was to be resident's physicial change of conditions change in status of the resident's designificant other.  F:278	PA's sacral pressure ulcer he rounds.  It p.m. the director of nursing ewed and stated R94's family all have been notified on ge in condition of R94's ulcers. It dan incident report or nurses of not be located indicating curred.  It is of condition policy reviewed a change in skin assessed and reported to the in a timely manner. The in policy further directed a faresident was to be reported esignated contact person/family ressment.  RESSMENT RDINATION/CERTIFIED hust accurately reflect the must conduct or coordinate with the appropriate			es:  ure S was  their wed	8-27-13
assessment is cor Each individual wh assessment must that portion of the	npleted.  o completes a portion of the sign and certify the accuracy of		c. An In-service on accume completing the MDS wheld on 8/2 & 8/6/2013 the MDS Nurses.  3. Date of Completion: 8/27/13	as	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; 2BBI11

Facility ID: 00299

If continuation sheet Page 4 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 093					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY GOMPLETED		
		245495	B, WING			07/1	18/2013	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		٠,	
EVERGR	EEN TERRACE				801 SOUTH HIGHWAY 169 BRAND RAPIDS, MN 55744			
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	( (X5) COMPLETION DATE	
F 278	false statement in a subject to a civil mo \$1,000 for each asswillfully and knowin to certify a material resident assessme penalty of not more assessment.  Clinical disagreement and false statement and false statement assessment.	gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each ent does not constitute a statement.	F		4. Reoccurrence will be prevented by:  a. A minimum of 4 MDS's was be audited weekly for 90 days to assure accurate coding. The results of the audits will be shared with the QA Committee for inponthe need to increase, decrease, or discontinue the audits.  5. The Correction will be monitored by:  DON/Designee	se ut		
· :	by: Based on observa review, the facility of Data Set (MDS) as	NT is not met as evidenced tion, interview and document did not ensure the Minimum sessment was accurate for 1 b) who had an indwelling						
	Findings include:		1				1	
,	obstructive pulmor	ncluded end stage chronic nary disease (COPD), left lung ibetes, anxiety, psychotic iratory failure.	The state of the s					
		ated 5/10/13, indicated R70 om the hospital with an catheter in place.						
		2 a.m. and on 7/18/13, at 9:01 erved in the room and had an						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: 20Bi11

Facility ID: 00299

If continuation sheet Page 6 of 34

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

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

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING			07/18/2013	
	ROVIDER OR SUPPLIER		•	280	REET ADDRESS, CITY, STATE, 2IP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DAYE
F 278	dated 5/30/13, indic	atheter.  nge Minimum Data Set (MDS)  cated R70 had severe	F	278		,	
<b>.</b>	mobility, transfers, supervision with ear required extensive personal hygiene. had an indwelling to Assessment (CAA) was independent worthnent of bowel	nt; was independent with bed and ambulation; required ting, and toilet use; and assistance with dressing, and The MDS did not identify R70 winary catheter. The Care Area dated 5/30/13, indicated R70 with all areas of mobility, was and bladder, and was able to CAA did not identify R70 had ry catheter.		The section is the second of t	F 282		8-21-13
F 282 \$\$=D	(RN)-A confirmed to did not identify R70 an error was made should have been 483.20(k)(3)(ii) SE PERSONS/PER C.  The services provided to the did not identify and the provided to the did not identify and the services.	00 a.m. the registered nurse the MDS was inaccurate and 0 had a catheter. RN-A stated and verified the catheter identified on the MDS. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F	282	<ol> <li>Corrective Action:         <ul> <li>The staff responsible for timely repositioning of resident # 164 was counseled and re-educated</li> </ul> </li> <li>Corrective Action as it applies to other resident and Procedifor repositioning was reviewed and remains current.</li> <li>All Residents care plan</li> </ol>	ted. e' t: ure	•
	by: Based on observa review, the facility repositioning interv	NT is not met as evidenced ation, interview, and document failed to provide every 2 hour rentions to reduce the risk of directed by the plan of care for	andream and the first of the fi		will be reviewed for accuracy c. An In-service on repositioning was held 8/7/13 for all nursing st d. An inservice on care ple will be held August 15 2013	8/6 & aff. ans	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI11

Facility ID: 00299

If continuation sheet Page 6 of 34

		AND HUMAN SERVICES				FORM	0: 07/31/2013 MAPPROVED
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		). 0938-0391 TE SURVEY MPLETED
`.		245495	B. WING	<b></b>		07	//18/2013
EVERGR	PROVIDER OR SUPPLIER			280	EET ADDRESS, CITY, STATE, ZIP COD 1 SOUTH HIGHWAY 169 AND RAPIDS, MN 55744	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	(OULD BE	COMPLETION DATE
F 282	Continued From pa 1 of 3 residents (Rulcers,	age 6 164) reviewed for pressure	F2	282	3. Date of Completion 8/27/13	•	
ķ	Findings include:				4. Reoccurrence will be prevented by:  a. A minimum of 4 N will be audited wee	ÆS's kly for	ļ
•	embolism and thro vessels, chronic pa	included acute venous mbosis of lower extremity ain, colostomy, neurogenic , anemia and quadriplegia.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		90 days to assure a coding. The results audits will be share the QA Committee on the need to incredecrease, or discon	of these d with for input pase,	
	R164 had a skin is and right outer ank and directed R164 every 2 hours. R16 7/15/13, directed R	ate initiated 7/15/13, indicated sue to the sacrum, low back, le and buttocks from pressure to be turned and repositioned 64's care plan date initiated 1164 required extensive ff with bed mobility and	The same of the sa		audits  5. The Correction wi monitored by: DON/Designee		
	sacral ulcer along right lateral ankle a	n [updated] noted R164 had a with ulcers on the low back and and directed R164 to be 2 hours while in the wheelchair nile in bed.			ı	ĸ	
÷		positioning Log dated 7/17/13, 64 was to be repositioned to side in bed.			,		
	continuous observ	7:20 a.m. to 9:58 a.m. ation occurred in the hallway room with R164's room door	1				

ORM CMS-2567(02-99) Previous Versions Obsolete

closed.

Event ID: 2BBI11

Facility ID: 00299

If continuation sheet Page 7 of 34

08-09-'13 16:44 FROM- Evergreen Terrace DEPARTMENT OF HEALTH AND HUMAN SERVICES

218-327-3217

T-207 P0008/0035 F-299

	V11V 11MV 10
FORM	APPROVED
MR NO	0938-0391

ENTE	48 FOR MEDICARE	& MEDICAID SERVICES				<u>OMR NO</u>	. 0938-0391
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l		CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245495	B. WING	i	·	07/	18/2013
AME OF I	PROVIDER OR SUPPLIER			ยาเ	REET ADDRESS, CITY, STATE, ZIP CODE	•	
VERGR	EEN TERRACE			5	01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 282	Findings include:  R164's diagnoses is embolism and throwessels, chronic pabladder and bowel,  R164's care plan de R164 had a skin is and right outer ank and directed R164 every 2 hours. R167/15/13, directed R164 every 2 hours. R167/15/13, directed R164 every 2 hours. R167/15/13, directed R164 every 2 hours side with A Tolleting and Redays, indicated R16 every 2 hours side.  On 7/17/13, from 7 continuous observations.	included acute venous imbosis of lower extremity lin, colostomy, neurogenic anemia and quadriplegia.  ate initiated 7/15/13, indicated sue to the sacrum, low back, le and buttocks from pressure to be turned and repositioned 64's care plan date initiated 164 required extensive ff with bed mobility and in [updated] noted R164 had a with ulcers on the low back and and directed R164 to be 2 hours while in the wheelchair nile in bed.		282	<ol> <li>Date of Completion: 8/27/13</li> <li>Reoccurrence will be prevented by:         <ul> <li>Visual audits of 2 residen per week on different Unix 90 days will be complet to assure repositioning neare being met timely per or plan. The results of these audits will be shared with the QA Committee for injon the need to increase, decrease, or discontinue the audits.</li> </ul> </li> <li>The Correction will be monitored by:         <ul> <li>DON/Designee</li> </ul> </li> </ol>	s ed ds are	

RM CMS-2667(02-99) Previous Versions Obsolete

dosed.

Event ID: 288I11

Facility ID: 00299

If continuation sheet Page 7 of 34

T-207 P0009/0035 F-299

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PRINTED:	07/31	/2013
FORM	APPR	<b>OBVC</b>
OMB NO	0020	0204

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM /	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI A. BUILE		E CONSTRUCTION	MB NO, 0938-0391 (X3) DATE SURVEY COMPLETED		
		245495	B. WING	i	· 	07 <i>1</i> ′	18/2013
	PROVIDER OR SUPPLIER			28	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 282	Continued From pa	ge 7	F:	282			
	knocked on R164's looked for the hoye not go all the way in	a.m. nursing assistant (NA)-C door, opened the door and r lift. NA-C was observed to nto R164's room, did not locate xited the room shutting the				-	
	entered R164's roo morning cares. R1 on the bed, position pillow under the left	a.m. NA-A knocked and m to provide R164 with 64 was observed to be laying ned on the right side with a t side. NA-A removed the add R164 on the back.				;	
	B knocked and en dressing change su to exit and re-enter dressing change su had gathered all the ready to perform w	7 a.m. registered nurse (RN) fered R164's carrying the upplies. RN-B was observed the room 2 more times for upplies. At 10:28 a.m. RN-B a needed supplies and was ound care and dressing various ulcers and wounds.					,
	entered R164's roo	5 a.m. NA-C knocked and om pushing the hoyer lift into nd RN-A used the hoyer lift to the wheelchair.					
	and referred to the Log for R164. NA- the log meant R164 and stated she did	p.m. NA-C was interviewed Turning and Repositioning C confirmed the 800 written on 4 was repositioned at 8:00 a.m. not turn or reposition R164 t write the 8:00 a.m. reposition		,			

JRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI11

Facility ID: 00299

If continuation sheet Page 8 of 34

on the log. NA-C further stated she was not sure

08-09-'13 16:44 FROM- Evergreen Terrace

218-327-3217

T-207 P0010/0035 F-299

		AND HUMAN SERVICES		•	FOR	RM APPROVED
TATEMEN	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) E	IO. 0938-0391 PATE SURVEY COMPLETED
		245 <b>4</b> 9 <b>5</b>	8. WING_			07/18/2013
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (		
EVERGE	EEN TERRACE	•		2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	turned or reposition R164's turning and ordered for every 2 bed.  On 7/17/13, at 1:47 and stated [he/she] repositioning log. No came on duty at 6:0 but did not provide NA-B also stated R repositioned around other 2 NA's workin R164's was due for R164 was suppose every 2 hours and virepositioned as ord On 7/17/13, at 2:42 to NA-A. On speak say [he/she] did no repositioning to R164's room around with morning cares	0 a.m. or who might have ed R164. NA-C verified repositioning schedule was hours, side to side, while in a.m. NA-B was interviewed wrote 800 on the IA-B further stated [he/she] 00 a.m., checked in on R164 any turning or repositioning, 164 was due to be turned and d 8:00 a.m. and reminded the 19 day shift this date when repositioning. NA-B stated to be turned and repositioned verified R164 was not ered.  p.m. RN-B made a phone call for the phone, NA-A was heard to the provide turning and 34 this morning until entering d 10:00 a.m. to provide R164	F 28	32		

DRM CMS-2567(02-99) Previous Versions Obsolete

plan of care.

Event ID: 288111

Facility ID: 00299

If continuation sheet Page 9 of 34

repositioned every two hours as directed by the

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.

PRINTED: 07/31/2013 FORM APPROVED

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 A. BUILDING \_

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

245495

B. WING \_\_

07/18/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169

EVERGR	EEN 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 ( (X5) COMPLETIC COMPLICA COMPLETIC COMPLETIC COMPLETIC COMPLETIC COMPLETIC COMPLETIC	NC.
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 3	8-27: F314	-13
	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		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	
	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			
ORM CMS-2	2567(02-99) Previous Versions Obsolete Event ID: 28Bi11		Facility ID: 00299 If continuation sheet Page 10 of	of 34

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 28Bi11

Facility ID: 00299

If continuation sheet Page 10 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	07/31/2013 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
· .		245495	B. WING	)		07/1	8/2013
NAME OF P	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	EEN TERRACE			[ "	RAND RAPIDS, MN 55744	······································	
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F 314	inspection results of form indicated R16 in width by 4 cm in on the sacrum. The results on the 7/9/1 noted R 164 to have stage 2 pressure used along with a 0.3 cm the lower back [not factors and intervel assessment form of R164's sacrum as between 9 to 12 cm completion of drest repositioning ever	ral buttocks. The area of skin on the 7/9/13, skin assessment 4 had a 3 cm in length by 2 cm depth stage 4 pressure ulcer e are a of skin inspection 3, skin assessment form also be a 3 cm by 2 cm by 0.1 cm leer on the right outer ankle in by 1.0 cm pressure ulcer on a staged. The analysis of risk intions area on the 7/9/13, skin described the pressure ulcer on deep with undermining in and directed interventions of sing changes as ordered and 1 hour while up in the erry 2 hours side to side while in		314	<ul> <li>4. Reoccurrence will be prevented by:</li> <li>a. Visual audits of 2 residen 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 inj on the need to increase, decrease, or discontinue to audits.</li> <li>5. The Correction will be monitored by: DON/Designee</li> </ul>	l put	
!	R164 had a skin is and right outer and and directed R164 every 2 hours. R1 7/15/13, directed F assistance of 2 statransfers.  A Pocket Care Plasacral ulcer along right lateral ankles	late initiated 7/15/13, indicated sue to the sacrum, low back, ide and buttocks from pressure to be turned and repositioned 64's care plan date initiated R164 required extensive off with bed mobility and with ulcers on the low back and and directed R164 to be 2 hours while in the wheelchair hile in bed.				83 	

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A Toileting and Repositioning Log dated 7/17/13, days, indicated R164 was to be repositioned

08-09-'13 16:45 FROM- Evergreen Terrace DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

218-327-3217

T-207 P0013/0035 F-299

FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245495	B. WING	) <sub></sub>		07/	18/2013
	PROVIDER OR SUPPLIER		<del>1 , , , , , , , , , , , , , , , , , , ,</del>		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		70720 10
(X4) ID PREFIX TAG	(ÉACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	DB⊵	(X5) COMPLETION OATE
F 314	every 2 hours side	to side in bed and listed under ere hand written entries of	F	314	1		
	continuous observa outside of R164's r	:20 a.m. to 9:58 a.m. etion occurred in the hallway oom with R164's room door ered the room for 2 hours and					
	knocked on R164's looked for the hove way into the room,	B a.m. nursing assistant (NA)-C door, opened the door and er lift. NA-C did not go all the the hoyer lift was not there and and closed the door.					
	entered R164's roo R164 was observe positioned on the r	3 a.m. NA-A knocked and om to provide morning cares. d to be laying on the bed, ight side with a pillow under the noved the pillow and positioned		,			
	-B knocked and en dressing change so to exit and re-ented dressing change so	17 a.m. registered nurse (RN) Itered R164's carrying the upplies. RN-B was observed I the room 2 more times for upplies and started wound care ges to R164's various ulcers					
	the right while RN-	28 a.m. NA-A turned R164 to B provided ulcer care to the					

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Event ID: 28Bi11

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T-207 P0014/0035 F-299

FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES	0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	. 245495	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		
oir a ps w 9 A w c n a ti d it h p a F ii c s a c g r r r	Id dressings and measured the wound at 3.5 cm a length by 1.8 cm in width by 3.2 cm in depth and stated R164's sacral ulcer was a stage 4 ressure ulcer; 90% granulation tissue and 10% lough; a moderate amount of serous drainage with no odor present; and had undermining at the o'clock to 12 o'clock position of 8.2 cm. appropriate wound care and dressing application was observed. After hand hygiene, RN-B leansed the left lower back ulcer area with a gauze and applied a small, foam dressing. RN-B stated the lower back ulcer was healed and the foam tressing was applied for protection of the area as a list located on a scar. RN-B performed hand applied new gloves and removed the wink 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 an length by 2.0 cm in width and stated the right puter 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 pressure to where R164 had both great toe nails emoved several weeks ago. The wound care procedures were completed at approximately 1:15 a.m. NA-C and RN-A assisted R164 via nover lift into the wheelchair at 11:15 a.m.	F 314				
	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 the log. NA-C further stated she was not sure who had written 8:00 a.m. or who might have					

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Event ID: 28BI11

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DEPART	MENT OF HEALTH	FROM- Evergreen Terrace AND HUMAN SERVICES & MEDICAID SERVICES	2	18-327-3217	T-207	FORM	35 F-299 35 F-299 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DAT	E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER	MA Principal Control	:	STREET ADDRESS, CITY, STA			
EVERGR	EEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55	744		
(X4) ID PREPIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	(D PREFIX TAG	CROSS-REFERENCE	E ACTION SHO	DULD BE	(X5) COMPLETION DATE
F 314	turned or reposition R164's turning and ordered for every 2 bed.  On 7/17/13, at 1:47 and stated [he/she repositioning log. It came on duty at 6: but did not provide NA-B also stated Frepositioned aroun other 2 NA's workin R164's was due for R164 was suppose every 2 hours and repositioned as order On 7/17/13, at 2:42 to NA-A. On spear	ned R164. NA-C verified repositioning schedule was hours, side to side, while in a.m. NA-B was interviewed wrote 800 on the NA-B further stated [he/she] 00 a.m., checked in on R164 any turning or repositioning. R164 was due to be turned and d 8:00 a.m. and reminded the ng day shift this date when repositioning. NA-B stated to be turned and repositioned verified R164 was not	F 3'	14			
	when morning car	164 until around 10:00 a.m. es were completed. 5 p.m. the director of nursing	a salahi langta a salahi salah				

DRM CMS-2567(02-99) Previous Versions Obsolete

hourly when in the chair.

plan of care.

Event ID; 2BBI11

Facility ID: 00299

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(DON) stated R164 should have been turned and repositioned every two hours as directed by the

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/31/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED <u>OMB NO. 0938-03</u>91 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_\_\_ - COMPLETED 245495 B, WING NAME OF PROVIDER OR SUPPLIER 07/18/2013 STREET ADDRESS, CITY, STATE, ZIP CODE **EVERGREEN TERRACE** 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX V (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 315 Continued From page 14 F 315 F 315 483.25(d) NO CATHETER, PREVENT UTI, F315 F 315 8-27-13 RESTORE BLADDER SS=D 1. Corrective Action: Based on the resident's comprehensive a. Resident #70 catheter was assessment, the facility must ensure that a discontinued on 7/18/13. resident who enters the facility without an indwelling catheter is not catheterized unless the 2. Corrective Action as it resident's clinical condition demonstrates that applies to other residents: catheterization was necessary; and a resident a. The Policy and Procedure who is incontinent of bladder receives appropriate for appropriate diagnosis for treatment and services to prevent urinary tract the use of an indwelling infections and to restore as much normal bladder catheter was reviewed and function as possible. remains current. b. All residents with indwelling catheters will be This REQUIREMENT is not met as evidenced reviewed to assure they have by: an acceptable diagnosis or Based on observation, interview and document condition for use. Any review, the facility did not ensure 1 of 1 residents Resident who handles their (R70) were comprehensively assessed and had own catheter bag will be documented medical justification for the educated on proper continued use of an indwelling urinary catheter. placement. c. An In-service on acceptable Findings include: diagnosis/conditions for use of an indwelling catheter was held on 8/6 & 8/7/13 for R70's diagnoses included end stage chronic all licensed muses obstructive pulmonary disease (COPD), left lung mass (2/2013), diabetes, anxiety, psychotic 3. Date of Completion: disorder, and respiratory failure. 8/27/13 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

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Discharge Instructions, hospital Progress Notes,

T-207 P0017/0035 F-299 FORM APPROVED

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TATEMENT ND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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F 315	and H& P (history a identify R70 had ar and there were no the catheter. A Hos R70 received Hosp illness starting 5/16 A Bladder Assessing R70 was continent to go to the bathroot R70 would use the if needed and had when short of brea bathroom. The asse had an indwelling uchange Minimum E indicated R70 had was independent was indicated R70 had ar The Care Area Asse indicated R70 was mobility, was continued and indwelling records lace evaluate and address and the catheter use and the catheter	and physical) Notes did not indwelling urinary catheter, physician's orders regarding pice Clinical Note indicated vice services for terminal	F	315	4. Reoccurrence will be prevented by: a. All new residents with indwelling catheters and new orders for indwelling catheters will be audited 90 days to assure the MI has given an acceptable diagnosis/condition for will be shared with the Committee for input on a need to increase, decrease or discontinue the audits  5. The Correction will be monitored by: DON/Designee	any g X ) sse. is A he	
	5/20/13, indicated I over R70's "anxiety	nd a Hospice Note dated R70's friend had a concern " over the catheter, and had er could be removed. The					

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notes further indicated when removal of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

218-327-3217

T-207 P0018/0035 F-299

FORM APPROVED
OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391	
STATEMENT AND PLAN O	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEN/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP			
		245495	B. WING	i		07/1	8/2013
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 BRAND RAPIDS, MN 55744		·
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F 315	stated she wanted conversation", and decided she would Hospice Note date called the Hospice she thought her ca needed to be chan Note indicated the facility nurse and the R70 had the cathe	age 16 ssed with R70 she initially it removed, but "after some "a lot of education" R70 wait and keep it "for now." A d 6/16/13, indicated R70 had nurse "very excited" because theter was not working, and it ged. Another 6/16/13, Hospice Hospice nurse contacted the ne facility nurse informed her fer tubing wrapped around her ntwisted it, and it was working	F	315			
	room lying on top of and had oxygen or catheter bag was I next to the upper rail oan do all my ow side of the bed and the room carrying closet and then to pair of gripper soc the room, and sat catheter bag direct placed the gripper	2 a.m. R70 was observed in the of the bed. R70 was dressed in via nasal cannula. A urinary nanging on a commode directly ight side of the bed. R70 stated on cares", and sat up on the clustood up. R70 ambulated in the urinary catheter bag to the the dresser. R70 obtained a ks and ambulated to a chair in down. R70 dropped the urinary tly on the floor by the chair and socks on her feet. No as noted during the observation.					
	sitting in a chair. T directly on the floo no one had ever to catheter bag on the the catheter taken take it out. R70 sta	1 a.m. R70 was in the room he urinary catheter bag was be beside the chair. R70 stated bld her not to place the urinary he floor. R70 added, she wanted out and the facility would not ated she was unsure why she and didn't like it because "it was					

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Event ID: 2BBl11

Facility ID: 00299

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/31/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER;** A. BUILDING COMPLETED 245495 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY F 315 Continued From page 17 F 315 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. 483.25(I) DRUG REGIMEN IS FREE FROM F 329 ! F329 F 329 **UNNECESSARY DRUGS** SS=D 1. Corrective Action: 8-27-13 a. Resident #23 Pencid was Each resident's drug regimen must be free from discontinued on unnecessary drugs. An unnecessary drug is any 7/22/13. drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate 2. Corrective Action as it applies to other indications for its use; or in the presence of residents: adverse consequences which indicate the dose a. The Policy and Procedure should be reduced or discontinued; or any combinations of the reasons above. for medication review for indications of use Based on a comprehensive assessment of a was reviewed and resident, the facility must ensure that residents revised. who have not used antipsychotic drugs are not

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Event ID: 28BI11

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		AND HUMAN ŞERVICES & MEDICAID SERVIÇEŞ			•	FORM	APPROVED . 0938-0391
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. ,		245495	B. WING		<del></del>	07/	18/2013
	PROVIDER OR SUPPLIER			28	TREET AODRESS, CITY, STATE, ZIP CODE 801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	1 011	10/20 10
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F 329	given these drugs to therapy is necessar as diagnosed and co record; and residen drugs receive gradu behavioral interven	ge 18 inless antipsychotic drug y to treat a specific condition locumented in the clinical ts who use antipsychotic ual dose reductions, and lions, unless clinically an effort to discontinue these	F	329	<ul> <li>b. An In-service on documentation of sliding scale Insulin and indication for use for medications was held o 8/6 &amp; 8/7/13 for all licensed nurses.</li> <li>3. Date of Completion: 8/27/13.</li> </ul>		
	by: Based on interview facility did not ident clinical indications facid reducing medic (R70) whose medic Findings include: R23 received famol (mg) every evening 6/10/10, with no do physician of indicat medication.  R23's diagnosis income quarterly Mining 4/24/13, indicated F	and document review, the ify, assess, and monitor, or continued use of a stomach cation for 1 of 10 residents rations were reviewed.  Itidine (Pepcid) 20 milligrams (reduces stomach acid) since cumentation from the ions for continued use of the luded history of a peptic ulcer. num Data Set (MDS) dated R23 had no cognitive			4. Reoccurrence will be prevented by:  a. The Consultant Pharmacist will be educated on reviewing long term medication assure indications for use are current. An audit of all monthly Pharmacist reviews who be conducted for 90 days as well to assure medications such as Pepcid have indication for use if given over a longer period of time. The results of these audits will be shared with the QA Commit for input on the need increase, decrease, or discontinue the audit	ill stee to	
	impairment. The Mi any gastrointestinal	DS did not identify R23 had diagnoses.		1	5. The Correction will be monitored by: DON/Consultant	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI11

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Pharmacist.

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A Discharge Summary dated 6/10/10, indicated

CENTERS FOR MEDICARE & MEDICAID SERVICES

218-327-3217

T-207 P0021/0035 F-299

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		245495	B. WING		-	07/	18/2013	
	ROVIDER OR SUPPLIER			28	REET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE	
F 329	R23 was admitted orders for Pepcid 2 physician's orders 20 mg at bedtime of Medication Admini July 2013, indicate every evening at 8  A nurse practitions R23 had been refucion for pain, heartburn, or R23 had a recent in medication (Aricept the gastrointestinal related to the rece Aricept was discorlacked evidence R gastrointestinal syldocumentation fro indications for con On 7/18/13, at 2:0	to the facility with physician's 20 mg daily. The current dated 7/1/13, directed Pepcid every day for peptic ulcer. The stration Records for June and d R23 received the medication 300 p.m.  ar note dated 5/6/13, indicated using her medications and set stomach and nausea. R23. R23 denied any abdominal reflux symptoms. It was noted norease in dose of another of - for dementia), and it was felt I upset and nausea was likely int increase in dose so the ntinued. The medical records		329				
	documentation fro continued use of the On 7/18/13, at 1:5 pharmacist (CP) s diagnosis of gastro	m the physician for the			•			
F 333 SS≒D	483.25(m)(2) RES SIGNIFICANT ME	DENTS FREE OF ERRORS	F	333				

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Event ID: 28B111

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T-219 P0008/0009 F-321

•	RINTED: 07/31/2013 FORM APPROVED MB NO. 0938-0391
	(X3) DATE SURVEY COMPLEYED
	07/18/2013

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

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_\_\_\_ 245495 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE** GRAND RAPIDS, MN 55744 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ( (XE) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 8-27-13 F 333 | Continued From page 20 F 333 P 333 The facility must ensure that residents are free of. any significant medication errors. 1. Corrective Action: a. The sliding scale insulin was administered per This REQUIREMENT is not met as evidenced MD order for Resident #48. The issue Based on interview and document review the discovered was periodic facility failed to ensure sliding scale insulin was failure to document the administered and documented for 1 of 10 amount on the e-MAR. residents (R48) reviewed for unecessary 2. Corrective Action as it medications. applies to other resident: a. The Policy and Procedure Findings included: for administering Insulin, including documentation of R48 had diagnoses that included diabetes, acute amounts for sliding and chronic renal failure and chronic dependence scales was reviewed and on a respirator via tracheostomy. revised on 8/2/13. b. All residents receiving Physician orders signed 7/1/13, included Chemstrips (blood glucose monitoring) four times sliding scale Insulin will every day with Novolog insulin before meals and have their e-MAR reviewed to assure there at bedtime as needed per sliding scale. is a nursing order to Parameters for the administration of the sliding scale Novolog insulin starting on 12/21/12, were document the amount given as well as the as follows: blood sugar result. c. An In-service on 100 - 150 = 2 units documenting sliding 151 - 200 = 4 units scale Insulin on the e-201 - 250 = 6 units MAR was held on 8/6 & 251 - 300 = 8 units 8/7/13 for all licensed 301 - 350 = 10 units 351 - 400 = 12 unitsnurses. 401 - 450 = 14 units above 451 = 20 units and call the physician. Review of the electronic medication

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 288111

Facility ID: 00299

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			· Q	MB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE COMP	SURVEY LETED
•		245495	B. WING		<u> </u>	07/1	8/2013
NAME OF P	ROVIDER OR SUPPLIER		ļ		REET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	EEN TERRACE				RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE ]	COMPLETION DATE
F 333	through 7/17/13, in- levels were consist require sliding scale however, sliding scale however, sliding scale administered as dir sliding scale.  During the month of glucose, the EMAR scale insulin admin glucose on 11 of 30 blood glucose, the scale insulin admir glucose for 13 of 3 glucose, there was scale insulin admir glucose for 25 of 3 glucose, there was scale insulin admir glucose for 28 of 3  During the month of glucose for 28 of 3  During the month of glucose record lac insulin administrati on 17 of 31 days. I no documentation administration for of 31 days. For the was no documentation administration for of 31 days. For the was no documentation	rd (EMAR) from 4/1/13, dicated that blood glucose ently within the parameters to e insulin administration; ale insulin was not consistently ected by the physician ordered of 4/13, for the 7:00 a.m. blood lacked evidence of sliding distered for elevated blood days. For the 11:00 a.m. are was no evidence of sliding distration for elevated blood days. For the 5:00 p.m. blood no documentation of sliding distration for elevated blood days. For the 8:00 p.m. blood no documentation of sliding distration for elevated blood no documentation of sliding distration for elevated blood no documentation of sliding distration for elevated blood		333	3. Date of Completion: 8/27/13 4. Reoccurrence will be prevented by: a. Daily medication audit reports will printed and revied DON/designed at days. The result these audits will shared with the Committee for input on the new increase, decreased audits.  5. The Correction will be monitored by: DON/Consultant Pharmacist.	be w by 90 s of l be QA ed to ase, the	
	of 31 days.			-			

T-207 P0024/0035 F-299

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/31/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED 245495 B. WING 07/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE** GRAND RAPIDS, MN 55744 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 333 Continued From page 22 F 333 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

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and physically enter the amount..."

<u>'CENTI</u>	ERS FOR MEDICARE	& MEDICAID SERVICES				FOR	D: 07/31/201 M APPROVE
SIMIEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIP DING	LE CONSTRUCTION	(X3) D.	O. 0938-039 ATE SURVEY OMPLETED
NA45 OF	\	245495	B. WING				
	PROVIDER OR SUPPLIER REEN TERRACE			2	BTREET AODRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 3RAND RAPIDS, MN 55744	_[0	<u>7/18/2013                                    </u>
(X4) ID PREFIX TAG	I TEACH DESIGNATOR	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	iX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D DE	COMPLETION DATE
F 333	Continued From pag	ge 23	F3	33		<del></del> -	
· .	TOOM velilled that i	p.m. the director of nursing he sliding soale insulin was e DON stated that in was a ot documented.	4 PP - 1 PF				
	administers the med administration on the after the medications	d) Preparation and General icated the individual who ication dose records the resident's EMAR directly given. In no case should the istered the medications of the first recording the dications.		***************************************	·		
F 334 SS=D	medication administration and omitted dose. Sho somewhere." The CF insulin was not docum 483.25(n) INFLUENZ IMMUNIZATIONS	of stated he did not notice the nented, A AND PNEUMOCOCCAL	F 33	4	F 334	¥	8-27-13
	(i) Before offering the each resident, or the representative receive benefits and potential mmunization; (ii) Each resident is off mmunization October annually, unless the incontraindicated or the	s education regarding the side effects of the		- C + C + C + C + C + C + C + C + C + C	Corrective Action:     The Immunization consent has been revised to include education given.		
A CMS-2587	//00 00) Decide 1/						, [

Event ID: 288H1

Facility ID: 00299

If continuation sheet Page 24 of 34

08-09-'13 16:48 FROM- Evergreen Terrace 218-327-3217 T-207 P0026/0035 F-299 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/31/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_\_\_\_ COMPLETED 245495 B. WING .. 07/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE GRAND RAPIDS, MN 55744** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DAYE DEFICIENCY) F 334 | Continued From page 24 2. Corrective Action as it F 334 immunized during this time period; applies to other (iii) The resident or the resident's legal residents: a. The Policy and Procedure representative has the opportunity to refuse for vaccination immunization; and education was reviewed (iv) The resident's medical record includes documentation that indicates, at a minimum, the and revised. b. All resident who have foilowing: (A) That the resident or resident's legal received a Pneumovax representative was provided education regarding vaccination in 2013 will the benefits and potential side effects of influenza be provided the 2012-2013 VIS. immunization; and (B) That the resident either received the c. An In-service on influenza immunization or did not receive the vaccination education influenza immunization due to medical was held for all licensed contraindications or refusal. nurses on 8/6 & 8/7/13. The facility must develop policies and procedures 3. Date of Completion: that ensure that --8/27/13 (i) Before offering the pneumococcal immunization, each resident, or the resident's 4. Reoccurrence will be legal representative receives education regarding prevented by: the benefits and potential side effects of the a. All residents receiving the immunization: Pneumovax vaccination (ii) Each resident is offered a pneumococcal plus Influenza immunization, unless the immunization is vaccination will be medically contraindicated or the resident has audited for the next 90 already been immunized; days to assure the VIS (iii) The resident or the resident's legal education was given and representative has the opportunity to refuse copy maintained with immunization: and date of education

)RM CMS-2567(02-99) Previous Versions Obsolete

following:

Event ID: 288111

Pacility ID: 00299

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indicated. The results

of these audits will he

Committee for input on

decrease, or discontinue

shared with the OA.

the need to increase,

the audits.

(iv) The resident's medical record includes

(A) That the resident or resident's legal

the benefits and potential side effects of

(B) That the resident either received the

pneumococcal immunization; and

documentation that indicated, at a minimum, the

representative was provided education regarding

P0027/0035 F-299 PKINTED: U//31/2013 FORM APPROVED T-207

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC	<u>), 0938-0391</u>
	l' OF DEPICIENCIES DE GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245495	B. WING_		07	/18/2013
NAME OF	PROVIDER OR SUPPLIER		\ <u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		110/2010
EVERGR	REEN TERRACE			2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DAYE
F 334	pneumococcal imm the pneumococcal contraindication or (v) As an alternativ and practitioner rec pneumococcal imm years following the immunization, unle	nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal as medically contraindicated or resident's legal representative		5. The Correction will monitored by: DON/Consultant Pharmacist.	be	
	by: Based on interview facility did not ensure R100, R102) were vaccination, and/or vaccination, and/or the Influenza and Findings include; R3's medical recordindicate an Influenza administered as revaccination had evand refused. R3 with 5/9/12. The Pneumand Annual Influent by R3's representated and reducation regarding record indicated R3 the annual Influenzation wever, no documents.	NT is not met as evidenced v and document review, the are 4 of 5 residents (R3, R92, offered a Pneumococcal received the Influenza were provided education on Pneumococcal vaccines.  ds lacked documentation to a vaccination was quested, or if a Pneumococcal er been received, or offered as admitted to the facility on nococcal, Tetanus-Diptheria, za Vaccine(s) form was signed tive on 10/6/12, and included g all of the vaccines. The 3's representative requested as vaccine to be given; nentation was provided to beived the Influenza vaccine, In				

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Event ID: 2BB(11

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addition, the form was incomplete and lacked

CENTERS FOR MEDICARE & MEDICAID SERVICES

218-327-3217

T-207 P0028/0035 F-299

FORM APPROVED

OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
245495			B. WING		07	07/18/2013		
NAME OF PROVIDER OR SUPPLIER  EVERGREEN TERRACE				TREET ADDRESS, CITY, STATE, ZIP CO 801 SOUTH HIGHWAY 169 BRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)'	HOULD BE	(X6) COMPLETION DATE		
F 334	evidence the Pneureceived, or offered R92's medical received, or admitted to the fact Pneumococcal, Telinfluenza vaccines. The the Influenza vaccines and lacked eviden was received, or of R100's medical relindicate education benefits and the plantluenza and Pneumococcal, Telinfluenza and Pneumococcal, Telinfluenza and Pneumococcal, Telinfluenza and refused. R100's medical records lead to the fact of the vaccine was refused.  R102's medical relindicate a Pneumococcal, Telinfluenza vaccine received, or admitted to the fact of the provided regarding if the vaccine was refused.	mococcal vaccine was	-					

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Event ID: 28Bi11

Facility ID: 00299

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08-09-'13 16:49 FROM- Evergreen Terrace DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 218-327-3217

T-207 P0029/0035 F-299

FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ł	IPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED				
		245495	B. WING	· ·	07/	18/2013			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 SOUTH HIGHWAY 169 GRAND RAPIDS, MN 55744					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 334 F 428 SS=D	record indicated R1 vaccine on 9/19/12 and lacked evidence was received, or of On 7/18/13, at 1:48 (DON) confirmed the she had no further The Immunization I education would be legal representative potential side effect Pneumococcal immunication would be offered if medical record would be given, refused, or offered in the steep of the drug regimen of	In 102 received the Influenza and the Pneumococcal vaccine fered and refused.  In p.m. the director of nursing the above findings and stated documentation to provide.  Policy updated 2013, indicated a provided to residents and/or as regarding the benefits and the Influenza and nunizations. The Influenza fered in the fall through March the Pneumococcal vaccine needed. Documentation in the all include the education occines, and if the vaccine was contraindicated. The policy second Pneumococcal vaccine five (5) years following the indicated or refused.  EGIMEN REVIEW, REPORT ON of each resident must be note a month by a licensed list report any irregularities to clan, and the director of	F 4	F 428  1. Corrective Action a. Resident #23 Pepo discontinued on 7/22/13. b. Resident #48 receive	old was	8-27-13			
	The pharmacist muthe attending physic			discontinued on 7/22/13.	ved the alin per ver the id not				

RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 28Bl11

facility ID: 00209

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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
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 obronic 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 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 12 units 401 - 450 = 14 units 401 - 450 = 14 units 401 - 450 = 10 units 401 - 45	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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Event ID: 28BI11

Facility ID: 00299

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## 08-09-'13 16:50 FROM- Evergreen Terrace DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

218-327-3217

T-207 P0031/0035 F-299

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

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DA	(X3) DATE SURVEY COMPLETED		
		245495	B. WING		07	14012042
	PROVIDER OR SUPPLIER	·	286	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744	1 0/	/18/2013
(X4) ID PREPIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES . Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D RF	(X5) COMPLETION DATE
	administered as dissilding scale.  During the month of glucose, the EMAR scale insulin admin glucose on 11 of 30 blood glucose, the scale insulin admin glucose for 13 of 30 glucose, there was scale insulin admin glucose for 25 of 30 glucose, there was scale insulin admin glucose for 28 of 30 glucose, there was scale insulin administration on 17 of 31 days. For the was no documentate administration for elof 31 days. For the was no documentate administration for elof 31 days. For the scale insulin administration for elof 31 days. For the was no documentate administration for elof 31 days.  During the month of scale in the scale insulin administration for elof 31 days.	of 4/13, for the 7:00 a.m. blood lacked evidence of sliding istered for elevated blood days. For the 11:00 a.m. re was no evidence of sliding istration for elevated blood days. For the 5:00 p.m. blood no documentation of sliding istration for elevated blood days. For the 8:00 p.m. blood no documentation of sliding istration for elevated blood no documentation of sliding istration for elevated blood	F 428	4. Reoccurrence will be prevented by:  a. Visual audits of e-MAR for residents receiving sliding scale Insulin who be completed 2 X weekly on different Units X 90 days to assure the amount give is documented. The Consultant Pharmacist will be educated on reviewing long term medications for use are current. An audit of almonthly Pharmacist reviews will be conducted for 90 days as well to assure medications such as Pepcid have indication for use if given over a longer period of time. The results of these audits will be shared with the QA Committed for input on the need to increase, decrease, or discontinue the audits.  5. The Correction will be monitored by: DON/Consultant Pharmacist.	ill en	

RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 288I11

Facility (D: 00299

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T-207 P0032/0035 F-299

PRINTED: 07/31/2013 FORM APPROVED

CENTE	<u>RS FOR M</u> EDICARE	& MEDICAID SERVICES				FOR	D: 07/31/201; M APPROVED
OINTEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE	E CONSTRUCTION	OMB NO	O. 0938-039 ATE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER	245495	B. WING			07	7/18/2013
	REENTERRACE			28	REET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH HIGHWAY 169	· · · · · ·	10,2010
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	T	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPRO	Dec	(X5) COMPLETION DATE
	of 23 days. For the towas no documentation for electron of 23 days. For the towas no documentation for electron of 23 days. For the towas no documentation for electron of 23 days. During the hospitalized for seven of 23 days. During the hospitalized for seven of 23 days. During the hospitalized for seven of 24 days. For all the seven of the	f sliding scale insulin evated blood glucose for 17 5:00 p.m. blood glucose, there ion of sliding scale insulin evated blood glucose for 17 6:00 p.m. blood glucose, there on of sliding scale insulin evated blood glucose for 18 is month R48 was in days.  17/17/13, for the 7:00 a.m. was no documentation of administration for elevated if 17 days. For the 11:00 a.m. entation of sliding scale if for elevated blood glucose the 5:00 p.m. blood for elevated blood glucose if the 8:00 p.m. blood cocumentation of sliding iration for elevated blood days.  (RN)-C, interviewed on ., stated that all sliding scale umented on the EMAR. unt was not recorded o click a few more boyes	F 4:	28	DEFICIENCY)		
n m	JUN) Verified that the	m. the director of nursing e sliding scale insulin was DON stated that in was a documented.		Transferration when the transferration	•		

Event ID: 2BBI11

Facility ID: 00299

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08-09-'13 16:50 FROM- Evergreen Terrace 218-327-3217 T-207 P0033/0035 F-299 DEPARTMENT OF HEALTH AND HOMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ B. WING\_ 245495 07/18/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2801 SOUTH HIGHWAY 169 **EVERGREEN TERRACE GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 428 | Continued From page 31 F 428 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 wilhout 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

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Facility 10: 00299

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impairment. The MDS did not identify R23 had

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

any gastrointestinal diagnoses.

		AND HUMAN SERVICES				FORM	APPROVĘD
	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	L OVON MAIN	********			. 0938-0391
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION		E SURVEY IPLETED
		245495	B. WING			07/	18/2013
NAME OF	PROVIDER OR SUPPLIER			Sĩ	FREET ADDRESS, CITY, STATE, ZIP CODE		,
EVERGE	EEN TERRACE				801 SOUTH HIGHWAY 169 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
F 428	Continued From pa		F 4	28			
	Medication Adminis	very day for peptic ulcer. The tration Records for June and I R23 received the medication 00 p.m.					
	R23 had been refuse complaining of upset was on the Pepcid. pain, heartburn, or R23 had a recent in medication (Aricept the gastrointestinal related to the recent Aricept was discont lacked evidence R2 gastrointestinal symdocumentation from	note dated 5/6/13, indicated sing her medications and set stomach and nausea. R23 R23 denied any abdominal reflux symptoms. It was noted crease in dose of another - for dementia), and it was felt upset and nausea was likely tincrease in dose so the inued. The medical records 13 had any other aptoms, and there was no in the physician for clinical nued use of the medication.					
	confirmed the medi-	p.m. the RN manager (RN)-D cal records lacked the physician for the medication.					
T I I I I I I I I I I I I I I I I I I I	Reviews from 7/12/	lonthly Medication Regimen 11, to 7/15/13, indicated no vere made regarding the					
	expect to see a diag reflux disease (GEF	p.m. the CP stated he would gnosis of gastroesophageal RD) for long term use of the ave missed it. The CP ot made any					

)RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 28B111

Facility ID: 00299

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T-207 P0034/0035 F-299

08-09-'13 16:50 FROM- Evergreen Terrace

DEPART	MENT OF HEALTH	ROM- Evergreen Terrace AND HUMAN SERVICES & MEDICAID SERVICES	2	18-3	327-3217	Γ-207		5 F-299 APPROVED 0938-0391		
STATEMENT				(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED						
		245495	B. WING				07/	18/2013		
NAME OF P	ROVIDER OR SUPPLIER	***************************************		ST	REET ADDRESS, CITY, STATI	, ZIP COI	DĒ.	,,		
EVERGR	EEN TERRACE				01 SOUTH HIGHWAY 169 RAND RAPIDS, MN 557	14				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	IGTION SE O THE AP	HOULD BE	(X6) COMPLETION DATE		
F 428	Continued From parecommendations (Pepcid.	ige 33 to the facility regarding the	F.	128						
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FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID: 2BBI11

Facility ID: 00299

If continuation sheet Page 34 of 34

Printed: 07/19/2013 FORM APPROVED

F5492023 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 245495 B. WING 07/16/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **EVERGREEN TERRACE** 2801 SOUTH HIGHWAY 169 **GRAND RAPIDS, MN 55744** (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID Œ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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.

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

(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.

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

Printed: 07/19/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245495

B. WING \_

07/16/2013

NAME OF PROVIDER OR SUPPLIER

**EVERGREEN TERRACE** 

STREET ADDRESS, CITY, STATE, ZIP CODE

2801 SOUTH HIGHWAY 169

EVERGR		RAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
( 000 cm )	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring prevent a reoccurrence of the deficiency.  Evergreen Terrace is a 1-story building was constructed at different times. The original building was constructed in 1963, is 1 story with a par basement, and was determined to be of II(111) construction. In 1968 a one story without a basement, was constructed so west of the original building, and was det to be of Type II (111) construction. In 198 story addition was constructed to the nor original building, was determined to be a (111) construction, and is separated with fire barrier. This building is no longer use residents and is staff only. In 2001 two constructed so west of the original building is no longer use residents and is staff only. In 2001 two constructed to the nor original building, was determined to be a (111) construction, and is separated with fire barrier. This building is no longer use residents and is staff only. In 2001 two constructed to the nor original building, was determined to be a (111) construction, and is separated with fire barriers. The building is divided smoke zones by 30-minute and 2-hour fire barriers.  The facility is fully sprinkler protected instruction in the corridor system and in all sleeping rooms installed in accordance with NFPA 72 "The National Fire Alarm Code edition. The fire alarm system is monitored automatic fire department notification. Has areas have automatic fire detectors that at the fire alarm system in accordance with Minnesota State Fire Code (2007 edition). The facility has a capacity of 109 beds and the fire alarm system in accordance with Minnesota State Fire Code (2007 edition).	vith a 4 tial Type addition, uth and rermined 30 a one th of the type V a 2-hour ad by other one e west at wing ed to be with addition. Simoke I vith 1999 ed for azardous are on the b.	000	2BRI21 If continuation	sheet Page 2 of 3

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

Printed: 07/19/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	245495		B. WING _		07/1	07/16/2013		
	ROVIDER OR SUPPLIER		2801 S	OUTH HIG	STATE, ZIP CODE SHWAY 169 , MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 000	census of 83 at the The facility was sur			K 000				