

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5563

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective March 13, 2013, the facility is certified for 65 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

April 30, 2013

Medicare Provider # 24-5563

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

Dear Mr. Erickson:

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

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

Effective March 13, 2013, the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

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

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Colleen Leach". The signature is written in a cursive, flowing style.

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

April 30, 2013

RE: Project Number S5563023

Dear Mr. Erickson:

On February 21, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 1, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 1, 2013, effective March 13, 2013 and therefore remedies outlined in our letter to you dated February 21, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Colleen Leach". The signature is written in a cursive, flowing style.

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

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

Enclosure

cc: Licensing and Certification File

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 245563	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/1/2013
Name of Facility GREEN PINE ACRES NURSING HOME		Street Address, City, State, Zip Code 427 MAIN STREET NORTHEAST MENAHA, MN 56464

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0225</u> Reg. # <u>483.13(c)(1)(ii)-(iii), (c)(2) -</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0226</u> Reg. # <u>483.13(c)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>
ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>
ID Prefix <u>F0311</u> Reg. # <u>483.25(a)(2)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0327</u> Reg. # <u>483.25(i)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>
ID Prefix <u>F0431</u> Reg. # <u>483.60(b), (d), (e)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>	ID Prefix <u>F0520</u> Reg. # <u>483.75(o)(1)</u> LSC <u> </u>	Correction Completed <u>03/13/2013</u>
ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed	ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed	ID Prefix <u> </u> Reg. # <u> </u> LSC <u> </u>	Correction Completed

Reviewed By <u> </u> State Agency	Reviewed By <u>PK/cbl</u>	Date: <u>04/30/2013</u>	Signature of Surveyor: <u>10679</u>	Date: <u>04/01/2013</u>
Reviewed By <u> </u> CMS RO	Reviewed By <u> </u>	Date: <u> </u>	Signature of Surveyor: <u> </u>	Date: <u> </u>
Followup to Survey Completed on: <u>2/1/2013</u>		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2DB7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00678

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245563 2.STATE VENDOR OR MEDICAID NO. (L2) 475240600	3. NAME AND ADDRESS OF FACILITY (L3) GREEN PINE ACRES NURSING HOME (L4) 427 MAIN STREET NORTHEAST (L5) MENAHGA, MN (L6) 56464	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 3. Termination 5. Validation 7. On-Site Visit 2. Recertification 4. CHOW 6. Complaint 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 02/01/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 2 AOA 1 TJC 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP 09 ESRD 10 NF 11 ICF/IID 12 RHC 13 PTIP 14 CORF 15 ASC 16 HOSPICE 22 CLIA	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 65 (L18) 13.Total Certified Beds 65 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>1.</u> Acceptable POC <u>2.</u> Technical Personnel <u>3.</u> 24 Hour RN <u>4.</u> 7-Day RN (Rural SNF) <u>5.</u> Life Safety Code <u>6.</u> Scope of Services Limit <u>7.</u> Medical Director <u>8.</u> Patient Room Size <u>9.</u> Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF (L37) 18/19 SNF 65 (L38) 19 SNF (L39) ICF (L42) IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks		
17. SURVEYOR SIGNATURE <u>Yvonne Switajeski, HFE-NEII</u>	Date : 03/14/2013 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Nicole Steege, Program Specialist</u> 04/05/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT: _____	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____
22. ORIGINAL DATE OF PARTICIPATION 06/01/1991 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	30. REMARKS Posted 4/8/2013 ML DETERMINATION APPROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2DB7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00678

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

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Provider Number: 24-5563

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after March 13, 2013.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5853

February 21, 2013

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

RE: Project Number S5563023

Dear Mr. Erickson:

On February 1, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 13, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 13, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 1, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 1, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Green Pine Acres Nursing Home

February 21, 2013

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Christy Johnson". The signature is written in a cursive style with a large, stylized "C" and "J".

Christy Johnson, Unit Supervisor

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING MAR 06 2013	(X3) DATE SURVEY COMPLETED 02/01/2013
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GREEN PINE ACRES NURSING HOME

427 MAIN STREET NORTHEAST
MENAHA, MN 56464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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INITIAL COMMENTS

THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

F 225
SS=E

483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT
ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the

F 000

This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS-2567. However the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the Statement of Deficiencies.

F 225

Resident #59 had the incident of missing money. #56 had a fall of unknown origin. #85 had a bruising of unknown origin. #3 had feeding tube removed by another resident. If these things were to reoccur the investigation will be sent in to state immediately/ within 24 hours.

If money is reported missing by a resident the administrator will be notified immediately, state will be notified, and local police department will be notified. An investigation will be started immediately involving all staff assigned to that area. If the loss is substantiated as a result of the investigation appropriate corrective action will be taken. If we have an injury of unknown origin or other incident

3/13/2013

(X6) DATE

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

TITLE

Charles E. Watson

Administrator

03-04-13

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

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a thorough investigation was completed for 3 of 6 residents (R3, R56, R85) reviewed with issues involving potential mistreatment, neglect, abuse, and injuries of unknown origin; and failed to report immediately misappropriation of property for 1 of 1 resident (R59). Findings include: R3's gastrostomy feeding tube was pulled out by another resident without timely report to the State agency and lacked thorough investigation. The incident report dated 10/7/12, at 6:45 p.m. indicated a confused resident entered R3's room and pulled out his feeding tube with balloon inflated. The report to Office Health Facility Complaint (OHFC) dated 10/8/12, indicated the report was being filed for "physical abuse." The	F 225	which needs to be sent in to state, e.g. a resident pulling another resident's feeding tube out, the investigation will be sent in to state immediately/within 24 hours. When an incident occurs the report is completed and sent to state as soon as possible, within 24 hours. If the incident is related to missing money, an injury of unknown origin, removal of a feeding tube by another resident or other incident, it needs to be reported immediately/within 24 hours. This will be conveyed to all RN's who send in investigations to the state. DON to monitor by reviewing all reports and investigations that are sent in to state.		

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page 2 report was brief and documented a resident who lived across the hall from R3 entered his room and pulled out his feeding tube. Staff entered the room and found the feeding tube in his hand with the balloon still inflated. The DON stated there was no investigation as she believed the resident intended no harm. R3's feeding tube was replaced and resident moved to another location. R56 fell and sustained an injury of unknown origin (fractured hip) without thorough investigation to rule out potential neglect of care. The incident report dated 1/24/12, at 6:20 a.m. indicated a licensed practical nurse (LPN) heard alarm sound and found the resident in his room on the bathroom floor on left side. R56 complained of hip pain when transferred. The OHFC report, dated 1/24/12, indicated the report was being filed for "injuries of unknown source." The LPN was in report and heard alarm sounding. When she got to the door she heard a loud bang and resident hollered out. Lying on his left side in bathroom with his legs out of his bathroom and head towards the opposite door. No staff present in the room. Resident had been up 8 times during the night to go to bathroom. Complaints of hip pain and was sent to emergency room. R56 was diagnosed with fractured hip. The director of nursing (DON) stated on 1/31/13, at 2:00 p.m. that she had conducted the investigation. She verified the investigation did not include any interviews with nursing assistants or any other staff involved to determine if the plan of care was being followed at the time of the incident. DON stated she does not have separate files where she has additional investigation information other than what is sent to OHFC.	F 225			

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F 225	Continued From page 3 R85 sustained an injury of unknown origin without thorough investigation to determine if abuse/neglect occurred. The incident report dated 12/6/12, indicated that during the night shift at 2:34 a.m. staff noted a 5 x 7 centimeter (cm) raised purple bruised area on right wrist and a 2 x 1 and 3 x 1 cm maroon colored bruise on left forearm. The OHFC Report indicated staff reported while transferring resident with the PAL (mechanical standing) lift on 12/5/12, the resident put her hands on the inside of the PAL sling several times while transferring. Bruising on wrist and forearm is consistent with PAL sling placement. There is no alleged perpetrator and information is from credible source. Care plan updated to ensure proper hand placement. The DON stated she conducted the investigation and interviewed staff. She verified she does not document any interviews with staff during her investigations. The only investigative report is what is submitted to OHFC. The Greenwood Connections Neglect/Abuse Policy, dated 12/28/11, documents: 1). Ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property are reported immediately to the administrator of the facility, MN Department of Health and Common Entry Point. 2). Have evidence that all alleged violations are thoroughly investigated, ... R59 reported missing \$100.00 in February of 2012 and it was not reported and not thoroughly investigated.	F 225			

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NAME OF PROVIDER OR SUPPLIER

GREEN PINE ACRES NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

**427 MAIN STREET NORTHEAST
MENAHA, MN 56464**

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F 225	Continued From page 4 R59's quarterly Minimum Data Set (MDS), dated 01/10/2012, and quarterly MDS, dated 12/11/13, identified that R59 was moderately cognitively impaired. On 1/28/2013 at 7:00 p.m., R59 said she had one hundred dollars (\$100.00) taken from under her pillow. R59 said that she reported the missing money but they (the facility) didn't look very hard for it. R59's Green Pine Acres Resident Trust Request Form, dated 2/10/12, identified that R59 requested "\$100.00 check be made out to [R59] out of my resident account at Green Pine Acres Nursing Home." The request form's signature line was signed by R59. A note text in R59's progress note by social services, dated 2/10/2012 at 15:08 (3:08 p.m.), indicated that, "Writer delivered a purchase made on behalf of Res. And cash requested [from her resident account] to her. [R59] earlier request for transportation to shop for clothing was referred to the Activities director to address, next week (Res. Is aware of this)." A Resident Missing Items Procedure facility form, dated and timed 2/18/2012, at 1000 (10:00 am), identified that R59 was missing \$100.00. This missing items form identified that, "If the items(s) is/are not located within twenty-four (24) hours: step 9) RN notify the director of nursing and/or Administrator." Although this step had an initial, there was no indication when the director of nursing and/or the administrator where notified. A health status progress note, dated 2/21/2012, at 10:55 a.m. indicated "Late Entry: Note Text: Did talk with resident regarding missing money. Did search her room with another RN and no money was found. At first, she stated it was gone on the 17th and later she said was gone on the 10th. " The	F 225		

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F 225	Continued From page 5 missing items report indicated on 2/21/12, that R59 reported the money missing on the 18th. The investigation was dated 2/21/12, and signed by the DON. The DON interviewed R59, the receptionist, and two nursing assistants working on 2/17/12. There was no other investigation information available. When interviewed, on 2/1/2013 at 1:12 p.m. the social worker (SW) said that he was not involved in the process of missing items unless it was brought to his attention and that the director of nursing does the final investigation, then takes it to the administrator and they determine if there is anything to be done. During interview, on 2/1/2013 at 2:03 p.m., the administrator said that he did not remember when he was notified of the missing money. He was unable to provide additional information. On 02/1/2013, at 2:42 p.m., the DON said that she did not recall interviewing other individuals on other shifts. In addition, she said that the missing \$100.00 should have been reported and that she couldn't find where this had been done. A review of the facility's undated policy, entitled, Resident Missing Items Procedure, directed staff to: 1). Establish item missing. 2). Report the missing item to the team leader. 3) Team leader give note to head of housekeeping and laundry staff. 4). Team leader to notify RN. 5). Team leader call family or legal guardian of item missing 6). Team leader to document in nursing notes, item missing and notification to family or legal guardian. 7). RN to notify Director of Nursing and / or Administrator. 8). D.O.N. To	F 225			

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F 225	Continued From page 6 conduct an internal investigation if foul play suspected.	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy and procedures related to possible abuse and neglect to ensure a thorough investigation was completed for 3 of 6 residents (R3, R56, R85) reviewed with issues involving potential mistreatment, neglect, abuse, and injuries of unknown origin; and failed to report immediately misappropriation of property for 1 of 1 resident (R59). Findings include: R3's gastrostomy feeding tube was pulled out by another resident without timely report to the State agency and lacked thorough investigation. The incident report dated 10/7/12, at 6:45 p.m. indicated a confused resident entered R3's room and pulled out his feeding tube with balloon inflated. The report to Office Health Facility Complaint (OHFC) dated 10/8/12, indicated the report was being filed for "physical abuse." The report was brief and documented a resident who lived across the hall from R3 entered his room and pulled out his feeding tube. Staff entered the room and found the feeding tube in his hand with	F 226	Resident #59 had money missing. Resident #56 had a fall of unknown origin. Resident #85 had a bruise of unknown origin. Resident #3 had a feeding tube removed by another resident. If this should reoccur, all staff in the area will be interviewed. This information will be kept with the investigation report. If money is reported missing, unknown injury occurs or resident pulls out another resident's feeding tube, this will be reported to state. An investigation will be started immediately involving staff assigned to that area. The information obtained from the investigation will be kept with the investigation report. A complete investigation will be done on reported events of any type including if gastrostomy tube is removed by another resident, money is missing or injury of unknown source. While doing the investigation, all personnel on duty in that area will be included in the investigation. What is reported to the RN will be recorded and kept with the investigation even if all the information collected is not sent to state with the investigation report.	3/13/2013	

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F 226	Continued From page 7 the balloon still inflated. The DON stated there was no investigation as she believed the resident intended no harm. R3's feeding tube was replaced and resident moved to another location. R56 fell and sustained an injury of unknown origin (fractured hip) without thorough investigation to rule out potential neglect of care. The incident report dated 1/24/12, at 6:20 a.m. indicated a licensed practical nurse (LPN) heard alarm sound and found the resident in his room on the bathroom floor on left side. R56 complained of hip pain when transferred. The OHFC report, dated 1/24/12, indicated the report was being filed for "injuries of unknown source." The LPN was in report and heard alarm sounding. When she got to the door she heard a loud bang and resident hollered out. Lying on his left side in bathroom with his legs out of his bathroom and head towards the opposite door. No staff present in the room. Resident had been up 8 times during the night to go to bathroom. Complaints of hip pain and was sent to emergency room. R56 was diagnosed with fractured hip. The director of nursing (DON) stated on 1/31/13, at 2:00 p.m. that she had conducted the investigation. She verified the investigation did not include any interviews with nursing assistants or any other staff involved to determine if the plan of care was being followed at the time of the incident. DON stated she does not have separate files where she has additional investigation information other than what is sent to OHFC. R85 sustained an injury of unknown origin without thorough investigation to determine if abuse/neglect occurred.	F 226	This information will be given to all the RN's who send reports and investigations to state. DON will monitor all such incidents and assure all reports are sent to state.		

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F 226	Continued From page 8 The incident report dated 12/6/12, indicated that during the night shift at 2:34 a.m. staff noted a 5 x 7 centimeter (cm) raised purple bruised area on right wrist and a 2 x 1 and 3 x 1 cm maroon colored bruise on left forearm. The OHFC Report indicated staff reported while transferring resident with the PAL (mechanical standing) lift on 12/5/12, the resident put her hands on the inside of the PAL sling several times while transferring. Bruising on wrist and forearm is consistent with PAL sling placement. There is no alleged perpetrator and information is from credible source. Care plan updated to ensure proper hand placement. The DON stated she conducted the investigation and interviewed staff. She verified she does not document any interviews with staff during her investigations. The only investigative report is what is submitted to OHFC. The Greenwood Connections Neglect/Abuse Policy, dated 12/28/11, documents: 1). Ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property are reported immediately to the administrator of the facility, MN Department of Health and Common Entry Point. 2). Have evidence that all alleged violations are thoroughly investigated, ... R59 reported missing \$100.00 in February of 2012 and it was not reported and not thoroughly investigated. R59's quarterly Minimum Data Set (MDS), dated 01/10/2012, and quarterly MDS, dated 12/11/13, identified that R59 was moderately cognitively impaired. On 1/28/2013 at 7:00 p.m., R59 said	F 226			

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F 226	Continued From page 9 she had one hundred dollars (\$100.00) taken from under her pillow. R59 said that she reported the missing money but they (the facility) didn't look very hard for it. R59's Green Pine Acres Resident Trust Request Form, dated 2/10/12, identified that R59 requested "\$100.00 check be made out to [R59] out of my resident account at Green Pine Acres Nursing Home." The request form's signature line was signed by R59. A note text in R59's progress note by social services, dated 2/10/2012 at 15:08 (3:08 p.m.), indicated that, "Writer delivered a purchase made on behalf of Res. And cash requested [from her resident account] to her. [R59] earlier request for transportation to shop for clothing was referred to the Activities director to address, next week (Res. Is aware of this)." A Resident Missing Items Procedure facility form, dated and timed 2/18/2012, at 1000 (10:00 am), identified that R59 was missing \$100.00. This missing items form identified that, "If the items(s) is/are not located within twenty-four (24) hours: step 9) RN notify the director of nursing and/or Administrator." Although this step had an initial, there was no indication when the director of nursing and/or the administrator where notified. A health status progress note, dated 2/21/2012, at 10:55 a.m. indicated "Late Entry: Note Text: Did talk with resident regarding missing money. Did search her room with another RN and no money was found. At first, she stated it was gone on the 17th and later she said was gone on the 10th. " The missing items report indicated on 2/21/12, that R59 reported the money missing on the 18th. The investigation was dated 2/21/12, and signed by the DON. The DON interviewed R59, the	F 226			

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F 226	Continued From page 10 receptionist, and two nursing assistants working on 2/17/12. There was no other investigation information available. When interviewed, on 2/1/2013 at 1:12 p.m. the social worker (SW) said that he was not involved in the process of missing items unless it was brought to his attention and that the director of nursing does the final investigation, then takes it to the administrator and they determine if there is anything to be done. During interview, on 2/1/2013 at 2:03 p.m., the administrator said that he did not remember when he was notified of the missing money. He was unable to provide additional information. On 02/1/2013, at 2:42 p.m., the DON said that she did not recall interviewing other individuals on other shifts. In addition, she said that the missing \$100.00 should have been reported and that she couldn't find where this had been done. A review of the facility's undated policy, entitled, Resident Missing Items Procedure, directed staff to: 1). Establish item missing. 2). Report the missing item to the team leader. 3) Team leader give note to head of housekeeping and laundry staff. 4). Team leader to notify RN. 5). Team leader call family or legal guardian of item missing 6). Team leader to document in nursing notes, item missing and notification to family or legal guardian. 7). RN to notify Director of Nursing and / or Administrator. 8). D.O.N. To conduct an internal investigation if foul play suspected.	F 226			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	Resident #47 had auto locking brakes removed. Resident #71 is now		3/13/2013

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F 253	Continued From page 11 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain one or both sides of anti-rollback wheelchair brake devices according to manufacturer's recommendations for functional operation for 3 of 6 residents (R47, R71, R59) that utilized these devices on their wheelchairs. Findings include: R47 was reviewed for a fall on 1/9/13, that involved falling in the bathroom between the wheelchair and the sink. R47 was noted to have a brake device (SafeTMate) on her wheelchair; however, the device was not identified in the care plan or the post-fall review completed in the interdisciplinary notes the day of the fall. On 1/30/13 at 2:15 p.m., the director of nursing (DON) reported during interview R47 was actually not assessed for use of the SafeTMate brake and the nursing staff was not sure why she used a wheelchair with the device. The DON also verified the facility purchased a number of the devices last year following being introduced to them at a provider meeting. She added no training was provided to the nursing staff on proper use, application or functional operation checks. The DON said the devices could be used with residents who were at risk of falls and did not	F 253	deceased. Resident #59 had auto locking brakes checked and fixed so they are now working properly. All residents who have auto locking brakes on their wheelchair will have them checked by maintenance to be sure they are working properly. Any change in the list of residents with auto locking brakes will be given to maintenance by the primary RN. A list of each resident with auto locking brakes on their wheelchair will be made and given to maintenance personnel. Maintenance personnel will check weekly that these are on properly and working properly. They will fix any that are not working properly. They will date on the list when they checked the brakes. DON will monitor by checking monthly to be sure the list is accurate and that weekly checks are being done.		

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F 253	Continued From page 12 remember to manually lock the brakes on the chair themselves. On 1/31/13 at 1:30 p.m. the SafeTMate device used by R47 was checked for proper operation with maintenance staff-A and found to not be operating properly on both rear wheels and would not prevent the wheelchair from rolling away and lock the wheels when the resident was not in the chair. The device on two other wheelchairs used by R71 and R59 were also observed to lock only one rear wheel and the chair would rotate away from the resident if needed. Maintenance staff (MS)-A verified the three chairs were out of adjustment and needed to be repaired to work properly. MS-A also verified he applied the devices to wheelchairs, but the devices did not receive regular routine preventative maintenance checks for function and remained on the wheelchairs when they were stored and were used among different residents. MS-A also reported the only time he adjusted the wheelchair devices was when nursing staff reported they were not operating correctly. The manufacturer's instruction manual for the SafeTMate brake devices identified the anti-rollback device should be inspected periodically to ensure that all the mounting hardware was securely tightened and the brake arms were in proper adjustment. The instructions noted if the device was properly adjusted, it functioned as a back-up system that may reduce injuries when the factory brakes were not applied.	F 253			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	Care Plan will be updated on resident #39 related to dehydration. Care Plans will be updated on residents #6 and #39 related to adaptive seating. Care Plan	3/13/2013	

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F 280	Continued From page 13 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the plan of care to include identified interventions to reduce the risk of dehydration for 1 of 2 residents (R39) reviewed for dehydration; for 2 of 5 residents (R39, R6) for adaptive seating and positioning needs; and for 1 of 2 residents (R71) with rehabilitative nursing ambulation needs. Findings include: R39 did not have the care plan revised and updated to provide all relevant interventions for risk of dehydration and to provide optimal seating	F 280	will be updated on resident #1 related to ambulation ability. (Resident #71 is deceased) Care Plans will be updated as conditions change. Following a Dehydration Assessment, residents who are at high risk for dehydration, will have this information placed on their Care Plan. Interventions will be flagged to appear on the kardex so the NARs are aware of this. If a resident changes from one type of wheelchair to another, this will be put in the Care Plan. If a resident is no longer able to ambulate, this will be noted on the Care Plan. If a resident has a change in the type of chair they use, this will be conveyed in writing to OT and the DON. The DON will then check that this is on the Care Plan. If a resident's ambulation ability changes, this will be conveyed in writing to the RN in charge on nursing rehab and the DON. Monthly, the DON will monitor by running a report to see which residents are at high risk for dehydration, check that dehydration is addressed on the Care Plan and is accessible for the NAR to see on the kardex. The DON will check that changes in ambulatory ability and change in type of chair will be placed in the Care Plan.		

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F 280	Continued From page 14 and positioning. R39 had diagnoses that included chronic liver disease, hemiplegia, hypertension, constipation, urinary incontinence, dementia and anxiety. The change of status Minimum Data Set (MDS) dated 7/25/12, and the most recent MDS (readmission) dated 11/9/12, identified R39 as cognitively intact, as requiring extensive assistance for eating/drinking, with limitation in range of motion on one side and diuretic use was noted. In addition, each MDS identified R39 as unsteady and unable to balance without physical assistance and as requiring extensive assistance for mobility by wheelchair device. Neither MDS identified dehydration as a medical issue at the time of the assessment. R39 had been hospitalized from 11/1-11/5/12, for liver failure and was described in the discharge summary as moderately dehydrated and had received IV fluids during the hospital stay. The Care Area Assessment (CAA) for the 7/25/12, change of status MDS was triggered for risk of dehydration related to diuretic medication use, cerebrovascular accident, cognition/behaviors and weight change. The most recent facility dehydration risk assessment dated 1/7/13, identified R39 at high risk of dehydration and directed interventions of : fresh water in room twice daily, monitor weight and edema daily, notify physician of signs/symptoms of dehydration. R39's current care plan dated 1/5/10, for the	F 280					

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F 280	Continued From page 15 problem of potential for dehydration noted the same interventions as identified in the recent 1/7/13, dehydration risk assessment and also directed staff to encourage water with and between meals, meds and at bedtime; however, this last intervention had not been added to the current nursing assistant (NA) care sheets. The NA care sheet noted only to provide fresh water in room twice a day and as needed. The facility policy dated 9/2012, for dehydration risk identified interventions for those residents at high risk was to include all interventions for low and moderate risk and also the following: monitor intake, offer liquids hourly when awake, offer other forms of liquids, total intake daily and notify RN if intake less than 1200 cc/24 hours. These interventions in the policy for high risk were not included in R39's working care plan and were also not included in the current nursing assistant care sheets. The MDS nurse, registered nurse (RN)-D, verified on 1/31/13, at 1:00 p.m. R39 did not have the care plan revised for all the interventions directed in the current policy and that it was missed related to some nursing staffing changes at the time. Additionally, RN-D stated R39 was still at high risk, the care plan had been updated and ongoing monitoring should still be completed as per their policy. R39 also did not have the care plan revised to address individualized seating/positioning needs to enhance optimal positioning that enhanced comfort and functionality.	F 280			

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F 280	Continued From page 16 The 7/25/12, change of status MDS, CAA for activities of daily living noted R39 had contractures, utilized a wheelchair and could propel the wheelchair somewhat. The most recent occupational therapy (OT) assessment dated 10/9/12, noted poor sitting balance, pain and weakness and treatment was directed toward improving function and wheelchair management to enable R39 to propel wheelchair throughout the facility with right side extremities. Unit RN-B reported on 2/1/13, at 9:30 a.m. the first documentation that indicated R39 had been moved to the Homecrest (type of geri) chair was a nurse's note on 12/4/12, that stated: Up in Homecrest chair, no complaints of pain. There were scattered entries in the nurses notes since December that indicated seating was in the Homecrest chair and the care plan dated 1/8/13 noted the Homecrest chair use; however, it did not include all interventions that enhanced optimal positioning and comfort. The care plan did note the feet should be supported in the chair, but did not address the arm position or ankle/leg position or how and when to adjust the foot supports on the chair with or without the use of the ankle/foot brace (AFO). During the survey on 1/28/13, at 5:08 p.m. R39 was observed seated in a Homecrest geri-chair that she was unable to self propel and required one staff for movement. The Homecrest chair had an adjustable foot plate that did not support either foot and created inversion and plantar	F 280			

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F 280	Continued From page 17 flexion of both feet, including the left foot that was partially supported by a loose AFO brace. The left upper extremity and hand was not supported by padding or a pillow and was wedged against the left thigh. R39 stated she was not comfortable in the chair and the left arm was painful. R39 was moved into the dining room at 5:38 p.m. and did have a small pillow under the left hand; however, the feet were still not supported. R39 was again observed in the dining room on 1/31/13, at 8:00 a.m. in the Homecrest chair, but without the AFO on the left foot, just wearing a sock. The foot was plantar flexed and inverted and unsupported by the adjustable foot rest. RN-B reported on 2/1/13, at 9:30 a.m. there had not been another occupational therapy assessment referral completed when the chair was switched and only verbal discussions with the OT assistant had occurred, but positioning specifics for the left side extremities were not documented in the nurses notes or the care plan. R6 did not have the care plan revised to address individualized seating/positioning needs to enhance optimal positioning that enhanced comfort and functionality. R6 was noted to have a wheelchair that did not support and allow the feet to fully contact the floor for mobility/comfort/safety. R6 had diagnoses that included Alzheimer's disease and dementia, generalized pain, pyogenic arthritis, osteoporosis, and generalized osteoarthritis involving multiple sites.			F 280			

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STREET ADDRESS, CITY, STATE, ZIP CODE

**427 MAIN STREET NORTHEAST
MENAHA, MN 56464**

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F 280	Continued From page 18 The annual MDS dated 9/4/12, and quarterly MDS dated 11/27/12, identified R6 with cognitive independence, extensive assistance of one staff for mobility by wheelchair and impaired range of motion of all four upper and lower extremities. The CAA for the 9/4/12, MDS for activities of daily living noted limitations from arthritis and noted assistance was needed to propel the wheelchair. R6 was observed repeatedly during the survey, sitting in the wheelchair with only the toes and forefoot contacting the floor surface. Random observations were documented on 1/28/13, at 6:30 p.m. and 7:30 p.m., 1/29/13, at 11:20 a.m. and 11:45 a.m., 1/31/13, at 2:00 p.m. with R6 as she attempted to propel the wheelchair with minimal effectiveness using the stocking feet with contact only with the toes/forefoot and some attempt using the hands on the wheels. The toes were hyperextended at the metatarsal joints where R6 had foot deformities from arthritis. During interview with R6 on 1/28/13 at 6:30 p.m. she reported some chronic foot discomfort and stated, "My feet are all crippled up and I can't wear shoes." R6's care plan identified a focus area for mobility and had an intervention that noted: Can propel wheelchair when she desires to; assist of one to go to the rehab room (long distances). A foam cushion was noted in the wheelchair. The care plan also noted to remind the resident to put hands on lap before staff moves wheelchair and spoke covers on wheels to prevent bruising. The certified occupational therapy assistant	F 280		

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F 280	Continued From page 19 (COTA) verified on 1/30/13, at 12:00 p.m., R6 was already in a low chair, but the chair could be lower to provide better floor contact. The COTA also stated no seating referrals had been requested by OT for R6's seating issues. The COTA also stated there had been no training for nursing staff on wheelchair seating and positioning issues or what to look for to refer and added there had been "lots of turnover in nursing staff." RN-B reported during interview on 2/1/13, at 9:30 a.m. R6's care plan had not been revised to include interventions for proper seating, lower wheelchair, or foot contact with the floor for mobility. R71's care plan related to ambulation had not been revised. R71's diagnoses included dementia. The quarterly MDS dated 1/23/13, identified R71 as cognitively impaired and as requiring assistance with ambulation. The Care Area Assessment (CAA) regarding falls dated 10/31/12, indicated R71 had impaired balance requiring assistance of staff for transfers and ambulation. The CAA also indicated R71 was on a walking list and did work with nursing rehab though often refused. The revised plan of care (POC) dated 1/15/13, identified R71 ambulated independently with a walker during the day and stand by assist from staff in room at night at times. The POC indicated nursing rehab was working with R71 on balance.	F 280			

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F 280	Continued From page 20 The current nursing assistant (NA) resident care sheet for R71 indicated starting 1/23/13, R71 was to be walked to meals. On 1/31/13, at 8:35 a.m. R71 was observed sitting in wheelchair across from the nurses desk. At 10:00 a.m. NA-C stated R71 did not walk independently and licensed practical nurse (LPN) -E stated R71 was no longer independent with ambulation, and started using a wheel chair on 1/17/13. At 11:10 a.m. NA-C stated R71 could not walk and did not walk to meals. NA-C stated she was not unaware of R71 needing to walk to meals and was not aware it was on R71's care sheet. At 11:45 a.m. RN-A stated she was unaware R71 was not walking as indicated on R71 NA care sheet. RN-A stated R71 was to be walking to all meals with the NAs. RN-A stated R71's ambulation program was lacking from the R71's current POC. On 1/31/13, at 1:35 p.m. R71 was observed being ambulated with a transfer belt and front wheel walker by NA-C and NA-D, with NA-E pushing a wheelchair behind R71. R71 was able to ambulate approximately 25 feet, when her knees started to buckle and she was placed in the wheelchair. On 2/1/13, at 9:50 a.m. NA-H sated R71 was having a hard time walking and requiring two staff to transfer. NA-H stated one and a half weeks ago R71 was independent with her ambulation.	F 280		

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F 280	Continued From page 21 On 2/1/13, at 2:30 p.m. RN-B stated R71's POC needed to be revised.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a temporary care plan to identify interventions including activities of daily living, pain and pressure ulcer management for 1 of 1 resident (R82) in the sample who was newly admitted to the facility. Findings include: R82 was admitted to the facility on 1/26/2013, with pressure ulcers on the coccyx, right inner heel, outer edge of left foot, and left hip. A temporary care plan had not been completed at the time of the survey. The history and physical dated 1/25/2013, indicated R82 had fallen at home three to four days prior to admission to the hospital and was crawling around on her hands and knees and was unable to bear weight. During observation on 1/28/2013, at 3:56pm, R82 exhibited a pained facial expression. During cares on 1/29/2013, and on 1/31/2013, at 8:28 a.m., R82 verbally complained of pain and said, " Oww, Oww " when licensed practical nurse (LPN)-E lifted her right foot and then the	F 281	A temporary Care Plan will be started on resident #82 which will include activities of daily living, pain management and pressure ulcer management. Upon admission a temporary Care Plan will be started on the day of admission. This will include psychosocial, dressing, grooming, bathing, dentition, diet/ nutrition, mobility, bowel/bladder, communication/hearing, vision, cognition, behaviors, activities, code status, skin condition as known at the time of admission. DON to monitor all new admissions to see that a temporary Care Plan is in place.	3/13/2013

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F 281	Continued From page 22 left foot and applied heel protectors to both feet. LPN-E gently raised her right foot to apply gauze to pressure ulcer, raised the left foot to apply heel protectors, repositioned her to the right side to provide treatment to the left hip pressure ulcer, sprayed colloidal silver to the left hip pressure ulcer, repositioned her to the left side to provide pressure ulcer treatment to the coccyx and sprayed colloidal silver on the pressure ulcer on the coccyx. During an interview on 1/31/2013, at 1:33 p.m., registered nurse (RN)-C verified R82 did not have a temporary care plan and that she had not given the nursing assistants or charge nurses a written care sheet in order for them to provide activities of daily living cares, pressure ulcer treatments and pain management for R82. RN-C provided a blank temporary care plan form for R82 and stated she had not had time to complete the temporary care plan form but would complete it within seven days. RN-C stated she communicates orally to the rest of the nursing staff about providing pressure ulcer treatments and pain management for R82. On 1/31/2013, at 3:11 p.m., RN-C stated the facility does not have a policy on temporary care plans.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Resident #82 will receive adequate pain management including pain monitoring and assessing why the resident was refusing pain medications while indicating pain on a level of 7-8 out of 10. Resident #39 and #6 will have their	3/13/2013

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Continued From page 23

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and document review, the facility failed to provide necessary care and services for 1 of 1 resident (R82) reviewed who required pain management interventions and for 2 of 5 residents (R39, R6) utilizing wheelchairs that were not provided optimal seating and positioning.

Findings include:

R82 consistently had moderate to severe pain related to pressure ulcers on coccyx, right inner heel, outer edge of left foot, and left hip, which was not relieved with Tylenol (a pain medication recommended for mild to moderate pain) 650mg every four hours as needed.

R82 was admitted to the facility on 1/26/2013 with pressure ulcers on coccyx, right inner heel, outer edge of left foot, and left hip. R82 had diagnoses that included anemia, gastroenteritis and colitis. An initial Minimum Data Set (MDS) was not completed at the time of the survey. The medical record did not indicate R82's cognitive status. The history and physical dated 1/25/2013, indicated R82 had fallen at home three to four days prior to admission to the hospital and was crawling around on her hands and knees and was unable to bear weight. The history and physical also indicated R82 had apparently fallen and broken her left hip within the last year which had been repaired. In addition, R82 was noted to have chronic weakness and consumed two to three

F 309

wheelchairs reviewed and assessed by OT for optimal seating and positioning.

Pain management will be started on all residents who are on pain medication routinely or prn upon admission and all residents who are admitted after recent surgery.

Nursing Rehab will assess seating and positioning in wheelchairs when asked to by RN or LPN and convey findings in writing to primary RN.

Nursing Rehab RN will check all residents for positioning and seating in wheelchair quarterly.

DON will monitor that all residents who are on pain medication or who have had recent surgery are on pain monitoring upon admission.

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F 309	Continued From page 24 drinks of alcohol per day. During observation on 1/28/2013, at 3:56pm, R82 exhibited a pained facial expression. During cares on 1/29/2013, R82 verbally complained of pain and said, "Oww, Oww" when licensed practical nurse (LPN)-E lifted right foot and then left foot and applied heel protectors to both feet. On 1/30/13, at 7:02 a.m. trained medication aide (TMA)-A was observed to provide treatment to the pressure ulcer on the left outer heel. R82 stated she had pain "all over" at that time. On 1/31/2013, at 8:28 a.m., R82 verbally complained of pain and said, "Oww, Oww" and had a grimaced facial expression when TMA)-A gently raised the right foot to apply gauze to a pressure ulcer, raised left foot to apply heel protectors. She continued to have complaints of pain while TMA-A repositioned R82 to her right side to provide treatment to left hip pressure ulcer. TMA-A sprayed colloidal silver to left hip pressure ulcer, repositioned to her left side to provide pressure ulcer treatment to coccyx and sprayed colloidal silver on the pressure ulcer on the coccyx. R82 verbalized pain and had facial grimacing during the procedure. The physician's orders dated 1/26/2013, indicated Tylenol 650 (milligrams) mg every four hours as needed was the only pain medication ordered for R82's pain. A pain management progress note dated 1/27/2013, indicated pain level was 6-7 and R82 had stated, "Pain comes and goes, but never leaves all the way." A progress note dated	F 309			

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F 309	Continued From page 25 1/27/2013, indicated R82 rated pressure ulcer pain in heels, coccyx and left hip at seven out of ten and R82 refused pain medication (Tylenol), on all three shifts. A skin/wound progress note dated 1/27/13, documented R82 complained of moderate pain when dressing wounds. A pain management progress note dated 1/28/2013, indicated R82 complained of pain stating, "It's all over." R82 rated pain level at an eight out of ten and gave a verbal description of the pain. R82 rated the pain at a three out of ten when she received Tylenol 650 mg every four hours as needed, and rated the pain at an eight out of ten when she did not accept the Tylenol. During an interview on 1/31/2013, at 1:33 p.m., RN-C stated R82 was on a pain monitoring system in which the charge nurse monitored R82's pain every shift and wrote a narrative note if R82 complained of pain and described the pain. RN-C reviewed the progress notes from 1/26/2013 to 1/31/2013 and verified R82 had complained of pain all over and rated the pain a seven or eight out of ten on numerous shifts. RN-C stated R82 had routinely refused the Tylenol but had routinely accepted a physician's order for 15 milliliters (ml) of whiskey each evening. RN-C stated she was concerned about seeking an alternative pain medication because she was unsure how the pain medication would affect R82's consumption of whiskey each evening. RN-C verified R82 had significant, routine pain without relief from the Tylenol 650 mg every four hours. RN-C also stated she was unsure why the Hydrocodone (narcotic) was discontinued at the time of admission to the facility from the hospital. RN-C verified she had not further assessed R82's	F 309			

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F 309	Continued From page 26 pain and had not contacted the physician for possible alternative pain management for R82 since date of admission. RN-C stated she would inquire to the physician about a better pain management for R82. R39 was not consistently provided services to promote optimal seating and positioning to enhance comfort and functionality. The 7/25/12, Care Area Assessment (CAA) for activities of daily living noted R39 had contractures, utilized a wheelchair and could propel the wheelchair somewhat. The most recent readmission MDS dated 11/12/12, noted R39 required extensive assistance of one staff for mobility by wheelchair and had frequent pain rated five (1-10 scale) that also affected sleep. The most recent occupational therapy (OT) assessment dated 10/9/12 noted poor sitting balance, pain and weakness and treatment was directed toward improving function and wheelchair management to enable R39 to propel wheelchair throughout the facility with right side extremities. Unit registered nurse (RN)-B reported on 2/1/13, at 9:30 a.m. the first documentation that indicated R39 had been moved to the Homecrest (type of wheelchair/geri-chair) chair was a nurses note on 12/4/12 that stated: Up in Homecrest chair, no complaints of pain. There were scattered entries in the nurses notes since December that indicated seating was in the Homecrest chair. The care plan dated 1/8/13, noted the Homecrest chair use; however, it did not include all	F 309			

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NAME OF PROVIDER OR SUPPLIER

GREEN PINE ACRES NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

**427 MAIN STREET NORTHEAST
MENAHA, MN 56464**

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F 309	Continued From page 27 interventions that enhanced optimal positioning and comfort. The care plan did note the feet should be supported in the chair, but did not address the arm position or ankle/leg position or how and when to adjust the foot supports on the chair with or without the use of the ankle/foot brace (AFO). A health status progress noted dated 1/8/13 noted R39's right foot had started to develop foot drop; R39 transferred with Hoyer lift to Homecrest chair and no longer bore weight. It noted staff was instructed to ensure resident's feet were resting on the foot rest and was adjustable. Nursing rehab had reported R39 had more left hand discomfort with extension. The left foot was noted to not fit well into the AFO and a new brace was to be obtained. During the survey on 1/28/13 at 5:08 p.m. R39 was observed seated in a Homecrest geri-chair that she was unable to self propel and required one staff for movement. The Homecrest chair had an adjustable foot plate that did not support either foot and created inversion and plantar flexion of both feet, including the left foot that was partially supported by a loose AFO brace. The left upper extremity and hand was not supported by padding or a pillow and was wedged against the left thigh. R39 stated she was not comfortable in the chair and the left arm was painful. R39 was moved into the dining room at 5:38 p.m. and did have a small pillow under the left hand; however, the feet were still not supported. R39 was again observed in the dining room on 1/31/13 at 8:00 a.m. in the Homecrest chair, but without the AFO on the foot, just wearing a sock.	F 309		

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F 309	Continued From page 28 The foot was plantar flexed and inverted and unsupported by the adjustable foot rest. RN-B also reported on 2/1/13 at 9:30 a.m. there had not been another occupational therapy assessment referral completed when the chair was switched and only verbal discussions with the OT assistant had occurred, but positioning specifics for the left side extremities were not documented in the nurses notes or the care plan. R6's wheelchair did not support and allow the feet to fully contact the floor for mobility/comfort/safety. R6 had diagnoses that included Alzheimer's disease and dementia, generalized pain, pyogenic arthritis, osteoporosis, and generalized osteoarthritis involving multiple sites. The annual MDS dated 9/4/12, and quarterly MDS dated 11/27/12, identified R6 with cognitive independence, extensive assistance of one staff for mobility by wheelchair and impaired range of motion of all four upper and lower extremities. The CAA for the 9/4/12, MDS for activities of daily living noted limitations from arthritis and noted assistance was needed to propel the wheelchair. During interview with R6 on 1/28/13, at 6:30 p.m. she reported some chronic foot discomfort and stated, "My feet are all crippled up and I can't wear shoes." R6 was noted at that time to have feet dangling and not contacting the floor when in the wheelchair. R6 stated she did not have legrests for the chair.	F 309			

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

**427 MAIN STREET NORTHEAST
MENAHA, MN 56464**

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F 309	Continued From page 29 R6 was observed repeatedly during the survey, sitting in the wheelchair with only the toes and forefoot contacting the floor surface. Random observations were documented on 1/28/13, at 6:30 p.m. and 7:30 p.m., 1/29/13, at 11:20 a.m. and 11:45 a.m., and 1/31/13, at 2:00 p.m. with R6 as she attempted to propel the wheelchair with minimal effectiveness using the stocking feet with contact only with the toes/forefoot and some attempt using the hands on the wheels. The toes were hyperextended at the metatarsal joints where R6 had foot deformities from arthritis. During the 1/29/13, 11:20 a.m. observation, R6 was unable to get sufficient foot traction to propel the chair, did not use the arms on the wheels, and stated, "Help me." A staff then pushed R6 into the dining room and up to the table. R6 was observed 1/31/13, at 10:05 a.m. while pushed to the activity room for an activity by NA-A. The staff did not apply the legrests to the chair before moving R6 from her room to the activity room. When R6 was turned sharply to position under the table, the front wheel swiveled and struck R6's unsupported right foot/ankle that caused discomfort and caused R6 to loudly cry out, "Ouch, Hey." At 2:00 p.m. NA-A was asked if R6 had legrests in her room that could be applied to the chair for transport. A pair of legrests for the wheelchair were located in R6's closet. NA-A reported the R6 did not like to use the legrests. R6's care plan dated 12/5/12, identified a focus area for mobility and had an intervention that noted: Can propel wheelchair when she desires	F 309		

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F 309	Continued From page 30 to; assist of one to go to the rehab room (long distances). A foam cushion was noted in the wheelchair. The care plan also noted to remind the resident to put hands on lap before staff moves wheelchair and spoke covers on wheels to prevent bruising. The occupational therapy assistant (COTA) verified on 1/30/13, at 12:00 noon, R6 was already in a low chair, but the chair could be lower to provide better floor contact. The COTA also stated no seating referrals had been requested by OT for R6's seating issues. The COTA also stated there had been no training for nursing staff on wheelchair seating and positioning issues or what to look for to refer and added there had been "lots of turnover in nursing staff." The occupational therapist (OT-A) reported during telephone interview on 1/31/13, at 9:15 a.m. nursing staff and the COTA were to do screening for seating and positioning needs and most referrals to OT were for residents who came from the hospital. OT-A could only recall one referral for seating and that was related to a power chair. OT-A stated he had not done any training for staff on seating/positioning, but verified the seating conditions noted with R39 and R6 definitely had positioning needs that should be addressed. OT-A suggested OT-B be contacted because they were at the facility more often. OT-B was contacted on 1/31/13 at 9:30 a.m. and she also reported screening for seating needs was done by nursing/COTA. OT-B could not recall getting any referrals to assess seating for R6 or R39 and was not aware of mobility issues	F 309			

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F 309	Continued From page 31 for R6 or that R39 had been moved to a Homecrest chair. RN-B reported during interview on 2/1/13 at 9:30 a.m. R6's care plan had not been revised to include interventions for proper seating or foot contact with the floor for mobility and a referral to therapy of OT had not been completed and there were no policies that could be located that identified specific instructions for referral to therapy for positioning or other issues. RN-B stated most of the issues were verbally discussed with available facility staff but not referred to therapy or documented in the record.	F 309			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide planned ambulation services for 1 of 2 residents (R71) in the sample who received ambulation services. Findings include: R71 did not receive ambulation services according to her assessed needs. R71's diagnoses included dementia. The quarterly Minimum Data Set (MDS) dated 1/23/13, identified R71 as cognitively impaired and as requiring assistance with ambulation. The	F 311	Resident #1 will be assessed by PT as to ambulatory ability. (Resident #71 is now deceased) LPN/NAR to report to primary RN if a reduction in ambulation has occurred. Primary RN is then to assess why the resident is no longer ambulating and have PT assess if indicated. DON will monitor walking list weekly and convey to primary RN residents who are on the walking list who have not been ambulating.		3/13/2013

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F 311	Continued From page 32 Care Area Assessment (CAA) regarding falls dated 10/31/12, indicated R71 had impaired balance requiring assistance of staff for transfers and ambulation. The CAA also indicated R71 was on a walking list with nursing rehab although often refused. The 1/14/13, quarterly fall assessment indicated R71 was to ambulate with a walker and nursing rehab to work on balance. The plan of care (POC) dated 1/15/13, identified R71 ambulated independently with a walker during the day and with stand by assist from staff in room at night at times. The POC indicated nursing rehab was working with R71 on balance. The current nursing assistant (NA) resident care sheet for R71 indicated starting 1/23/13, R71 was to be walked to meals. Review of the 1/13, nursing ambulation sheet indicated: The day shift had ambulated R71 two out of 18 opportunities, and documented "4" and "8" feet. Five out of these 18 opportunities had been documented as "N/A" and two out of these 18 opportunities had been documented as "RR (resident refused)." The evening shift had ambulated R71 one out of 8 opportunities and documented "10" feet. Seven out of the 9 opportunities had been documented as "RR" and 1 as "0". On 1/31/13, at 8:35 a.m. R71 was observed	F 311			

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F 311	Continued From page 33 sitting in wheelchair across from the nurses desk. At 10:00 a.m. NA-C stated R71 did not walk independently and licensed practical nurse (LPN) -E stated R71 was no longer independent with ambulation, and had started using a wheelchair on 1/17/13. At 11:10 a.m. NA-C stated R71 could not walk and did not walk to meals. NA-C stated she was not unaware R71 was to walk to meals and was not aware it was on R71's care sheet. At 11:45 a.m. registered nurse (RN)-A stated she was unaware R71 was not walking as indicated on the NA care sheet. RN-A stated R71 was to walk to all meals with the NAs. RN-A stated R71's ambulation program was lacking from the POC. On 1/31/13, at 1:35 p.m. R71 was observed being ambulated with a transfer belt and front wheel walker by NA-C and NA-D, with NA-E pushing a wheelchair behind. R71 was able to ambulate approximately 25 feet, and then her knees started to buckle and she was placed in the wheelchair. At that time, NA-C stated that the night before, she had attempted to ambulate R71 from her bed to the bathroom and R71's knees started to buckle, so she sat R71 back into her wheelchair. NA-C, NA-D, and NA-E stated they thought PT (physical therapy) should evaluate R71 because they felt it was not safe to ambulate R71. On 2/1/13, at 9:50 a.m. NA-H stated R71 was having a hard time walking and required two staff to transfer. NA-H stated a week and a half ago,	F 311			

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STREET ADDRESS, CITY, STATE, ZIP CODE

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MENAHA, MN 56464**

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F 311	Continued From page 34 R71 had been independent with her ambulation, however, she had been sick with the flu. On 2/1/13, at 2:30 p.m. RN-B stated a referral had been sent to PT to have R71's ambulation evaluated. On 2/1/13, at 2:15 p.m. RN-C stated if nursing is ambulating a resident, ambulation will be added to the plan of care. On 2/1/13, at 2:25 p.m. the director of nursing (DON) stated R71 ambulation should be reviewed on a weekly basis and if the resident was refusing or ambulation was not being offered, the resident would be re-assessed. The DON stated the facility had lacked enough RNs to be able to do the task.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R63) who was at high risk for falls had alarms properly secured and functioning per manufacturers instructions.	F 323	Resident #63 will have tab alert secured to the bed. All residents who have tab alert on while in bed will have the tab alert secured to the bed. All residents who have a nursing order for a tab alert while in bed, will have tab alert secured to the bed. This is to be determined by primary RN with the input of the interdisciplinary team. This will be monitored by the DON monthly.	3/13/2013

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F 323	Continued From page 35 Findings include: R63 had 14 falls from 2/1/12 to 1/25/13. The wheelchair and bed sensor alarms were not always functioning at the time of the fall to alert staff of attempts to self transfer for 8 of the falls. In addition, the clip alarm was not being implemented while in bed according to manufacturers instructions which rendered it inoperable. R63 had diagnoses that included a history of falls, Alzheimer's disease, psychophysical visual disturbance, transient ischemic attack (mini stroke or episode of neurologic dysfunction), osteoporosis and a former closed fracture of the 1-4 cervical bones. The quarterly Minimum Data Set (MDS) dated 10/29/12, indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 5, two falls since the prior MDS dated 8/7/12, total dependence of two for bed mobility, extensive assistance for transfers, dressing, eating, toileting and personal hygiene and wheelchair mobility. The MDS indicated R63 was non-ambulatory. R63 also had functional limitations in range of motion in upper and lower extremities on both sides. The Care Area Assessment (CAA) for falls, dated 5/23/12 indicated R63 had been identified a fall risk with a history of multiple falls. The CAA indicated R63 tends to crawl out of bed or chair and does not always alert staff to needs. The care plan dated 6/30/11, and revised 1/22/13, directed caregivers to check the	F 323			

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NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 36 batteries in the sensor pads on the wheelchair and bed. In addition, the care plan directed, "nursing to check to ensure alarms are hooked up once resident is in bed. To assure alarms are in place, turned on and functioning properly, on each shift when he was in bed." The fall risk assessments dated 1/21/13, 10/29/12, 8/6/12, 5/14/12, 2/6/12 and 11/25/11, consisted of multiple falls, crawling out of bed or wheelchair, and each assessment identified R63 at high risk for falls. Review of the facility's fall investigations timeline and summary are as follows: - 1/6/12 at 7:50 a.m. found in bedroom with knees on mat and leaning upper body on the bed. The tab alarm was connected to the resident, alarm not sounding. Noted tab alarm attached on his right side and wanted it attached on the left side. -2/1/12 at 7:20 p.m. found on knees in his bedroom. He had removed the wheelchair tray and sensor alarm did not sound. -3/22/12 at 8:25 P.M. a witnessed attempt to get out of wheelchair and slid to floor. The wheelchair alarm sounded, the TAB alarm was not sounding. Location was south hallway. -5/4/12 at 2:30 a.m. found on knees in bedroom with alarm sounding. -5/19/12 at 11:35 p.m. found sitting on the floor in his bedroom. The TAB (product name) alarm was still connected but too close to sound the	F 323			

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F 323	Continued From page 37 alarm. The bed alarm did not sound. -5/24/12 at 9:50 a.m. found on knees in bedroom with upper body on the bed. No alarms sounded. The alarm clip was on the gown and alarm not sounding. -5/25/12 at 2:35 a.m. found on knees in bedroom with TAB alarm in his hand and upper body leaning on the bed. No alarms sounded. -6/5/12 at 2:30 p.m. sliding from wheelchair to the floor was witnessed and an alarm was sounding. -7/14/12 at 10:00 p.m. found on floor in his bedroom laying on 1/2 of the alarm, which was sounding. -8/29/12 at 9:00 p.m. sliding out of wheelchair, sat on wheelchair footrests. -8/30/12 at 9:00 p.m. found on floor in bedroom with no alarm sounding. The bed alarm was not hooked up. The TAB alarm was clipped to the resident but the box was in the bed, not alarming. -10/16/12 at 9:45 p.m. found on the floor mat in his bedroom with the alarm sounding. -1/25/13 at 12:35 a.m. found on floor by the sink. The TAB alarm was attached to the gown, but the box was not sounding. The bed alarm was blinking but the cord was not inserted into the alarm box, so was not sounding. The resident sustained a bruise to the left elbow. The new intervention was for "Once resident is in bed, check to make sure alarms are in place, turned on and functioning properly. Remind nursing staff	F 323			

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F 323	Continued From page 38 to check resident every hour once in bed." On 1/30/13 at 7:12 a.m. R63 was near the nursing desk in a wheelchair with an acrylic tray in front of him. At 9:55 a.m. nursing assistant (NA)-C and NA-F were going to transfer R63 to a commode in his room. NA-D entered the room at 10:04 a.m. with a mechanical assist lift to transfer him from wheelchair to commode. R63 had the ability to grasp his hands on the lift bars and did so. NA-F, NA-C and NA-D were unable to provide information related to R63's fall and stated the nurses do that. The NA's did explain the alarms are placed in the cloth bag that hangs at the back of the wheelchair and when he was in bed the alarms were also in the bags for the TAB alarm clipped to his clothing or the bed sensor alarm. On 1/30/13, at 1:40 p.m. R63 was observed to repeat a transfer from the commode to the bed. Bilateral leg braces were placed, a spacer pillow between his knees, a supportive neck pillow, floor mat next to the low bed, a bed sensor alarm and a TAB alarm clipped on the left shoulder of his shirt. Both alarms were also used while R63 was in the wheelchair. At 3:30 p.m. R63 was observed in bed on his back. The TAB (clip) alarm was clipped to his shirt on left shoulder. However, the alarm was lying on mattress next to pillow not affixed to permanent object. NA-G was interviewed at the time regarding the alarm. She verified observations and stated they (NAs) do not attach the alarm box to anything and demonstrated how the magnet comes off the alarm box when pulled. NA-G added that they make sure the alarm is clipped to the opposite side R63 is lying so he does not remove.	F 323			

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F 323	Continued From page 39 On 1/31/13, at 7:30 a.m. licensed practical nurse (LPN)-D, stated the night shift staff would get R63 out of bed and dressed if he was restless. LPN-D stated R63 will rise at 4:00 a.m. or anytime of day. On 1/31/13 at 1:45 p.m. NA-C stated R63 does have the strength in arms to push the acrylic tray off the wheelchair "with a big bang." The tray slides forward to come off the wheelchair and he will push on it when he gets restless. NA-C further explained R63 cannot get back into bed or attempt to stand if he is on his knees on the floor mat by the bed. On 1/31/13, at 11:15 a.m. the registered nurse (RN)-C stated any resident fall on the afternoon or night shift is reported the next day. As the RN she reviewed all falls and does the investigation and follow-up. RN-C stated R63 used a TAB alarm in the wheelchair and also a sensor alarm. She stated, "It sounds depending on how they clip it. It should be positioned on the opposite side of the alarm, no specific area on the shirt. The alarm is in a bag strapped on the back of the wheelchair. He also used a slide assist pad in the wheelchair to prevent sliding out of the wheelchair." In addition, RN-C stated there is a Velcro bag for the sensor alarm which hangs or clips on the mattress or headboard. At 11:56 a.m. RN-C stated before fall interventions are determined the interdisciplinary team discussed the falls report in the morning meetings. The falls committee also meets monthly to review resident falls. RN-C was questioned about the placement of the TAB alarm when in bed and verified that the alarm may be	F 323			

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F 323	Continued From page 40 inoperable if it is not attached to a permanent location. She added that she was not aware the staff were not resting the alarm on the mattress versus affixing to headboard. RN-C verified the TAB alarm would not be effective if it fell along with the resident. The length of the alarm string needs to be long enough to get up to the Velcro strip on the headboard of the bed. On 1/31/13 at 2:05 p.m. the director of nursing (DON) was interviewed regarding R63's falls and interventions. She stated R63 did not ambulate since admission in 2011. The acrylic tray intervention for falls was implemented in 4/12, as he tries to get out of wheelchair. Both sensor and clip alarms while in his low bed as he tried to crawl out of bed if restless. The DON added the falls committee discussed every resident fall, what happened and analyzed what was going on. When asked about placement of the TAB alarm in bed, she stated that they have been monitoring to assure alarms are in place but did not check to make sure the alarms were secured. She verified the alarms should be attached to headboard or some other object. The DON stated the facility lacked an alarm policy. The manufacturer's instructions for the AllMed IQ Duo Plus Alarm #711290 alarm (utilized by R63) indicated, read entire instruction sheet before using alarm, failure to do so may result in injury or death to a person in your care. The manufacturer instructions addresses the use of hanging straps to secure the alarm. - Remove alarm unit from holster. - Remove plastic wrap from cleanable strap.	F 323			

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NAME OF PROVIDER OR SUPPLIER

GREEN PINE ACRES NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

**427 MAIN STREET NORTHEAST
MENAHA, MN 56464**

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F 323	Continued From page 41 - Unclip strap by removing loose end from buckle strap. - Wrap strap around slots in back of holster. - Once alarm strap is inserted properly, slide buckle back onto strap. - Wrap plastic strap around arm of chair or rail of bed and click buckle shut. - Adjust size of strap around chair or bed by sliding the black strap through the adjustable clip. - Place alarm into mounting holster.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services according to facility policy to address hydration needs for 1 of 2 residents (R39) in the sample who demonstrated signs and symptoms of dehydration. Findings include: R39 had diagnoses that included chronic liver disease, constipation, urinary incontinence, and dementia. The change of status Minimum Data Set (MDS) dated 7/25/12, and the most recent MDS (readmission) dated 11/9/12, identified R39 as cognitively intact, and as requiring extensive assistance for eating/drinking. Limitations in range of motion on one side and diuretic use was also noted. Neither MDS identified dehydration as	F 327	Resident #39 will have interventions in place as appropriate as the most recent Dehydration Assessment indicates. These interventions are: fresh water in room twice a day, monitor intake every shift, notify primary RN if intake is less than 1200cc/day. Dehydration Assessments are done upon admission and quarterly on all residents. All residents will have interventions in place as Dehydration Assessment indicates. These interventions will be in the Care Plan and flagged to show on the kardex for NAR to view. DON will monitor by checking monthly that Dehydration Assessments are done and appropriate interventions are in place for residents at risk for dehydration. DON will check monthly that residents at high risk for dehydration have this in the Care Plan and it is flagged on the kardex.	3/13/2013

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F 327	Continued From page 42. a medical issue at the time of the assessments. R39 had been hospitalized from 11/1-11/5/12, for liver failure and was described in the discharge summary as moderately dehydrated with dry oral mucosa and had received intravenous (IV) fluids during the hospital stay for that condition. The Care Area Assessment (CAA) for the 7/25/12, was triggered for risk of dehydration related to diuretic medication use, cerebrovascular accident, cognition/behaviors and weight change. The most recent facility dehydration risk assessment dated 1/7/13, identified R39 at high risk of dehydration and directed interventions of : fresh water in room twice daily, monitor weight and edema daily, and notify physician of signs/symptoms of dehydration. R39's current care plan dated 1/5/10, for the problem of potential for dehydration noted the same interventions as identified in the recent 1/7/13, dehydration risk assessment and also directed staff to encourage water with and between meals, meds and at bedtime. However, this intervention had not been added to the current nursing assistant (NA) care sheets. The NA care sheet noted only to provide fresh water in room twice a day and as needed. During interview with R39 on 1/28/13, at 5:19 p.m. she reported she was thirsty and requested water to drink. There was a glass of water observed across the room on the dresser/sink area. R39 was also noted to have a dry mouth and cracking of the lips and breathed with the	F 327			

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F 327	Continued From page 43 mouth open. The policy dated 9/2012, for dehydration risk, identified interventions for those residents at high risk was to include all interventions for low and moderate risk and also the following: monitor intake, offer liquids hourly when awake, offer other forms of liquids, total intake daily and notify RN (registered nurse) if intake less than 1200 cc/24 hours. These interventions in the policy for high risk were not included in R39's working care plan and were also not included in the current nursing assistant care sheets. The MDS nurse, RN-D, verified on 1/31/13, at 1:00 p.m. R39 did not have her care plan revised for all the interventions for dehydration as directed in the current policy and had been missed related to some earlier nursing staffing changes. Additionally, RN-D stated R39 was still at high risk, the care plan had been updated that day and ongoing intake monitoring should still be completed as per their policy.	F 327			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	Residents #28, #62, #22, #42 and #41 will have indicated on the emar how to dispose of Fentanyl Patch - to cut up and flush down the toilet. All residents who have Fentanyl Patches will have indicated on the emar how to dispose of the patch and also have this co-signed by another LPN/ RN/TMA.	3/13/2013	

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F 431	Continued From page 44 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow currently accepted principles for the disposal of controlled substances for 5 of 5 residents (R28, R62, R22, R42, and R41) who were prescribed Fentanyl patches. Findings include: During the medication storage review conducted on 1/31/13, at 2:45 p.m. licensed practical nurses (LPN)-A and LPN-B both verified used Fentanyl	F 431	Policy will be written indicating the correct way to dispose of Fentanyl Patches - cutting up and flushing down the toilet. A copy of this policy will be given to each nurse and TMA. This will be monitored by DON by checking the emar monthly relating to charting of Fentanyl Patch disposal.	

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F 431	Continued From page 45 patches prescribed to residents were routinely disposed of by folding the patch and placing them into the sharps containers on the medication cart. The full sharps containers were then placed in a utility/equipment room until picked up by the waste vendor. LPN-B reported there were five residents in the facility that were currently prescribed Fentanyl patches: R28, R62, R22, R42 and R41. LPN-A also verified the pharmacy consultant had informed the facility the patches should be disposed of by cutting, flushing and/or witnessed destruction. However, the facility had not initiated that procedure largely because of the difficulty in getting another licensed staff to witness the process. LPN-B also reported the nurses dated the patches when applied, but they were routinely not checked again until the time they were to be changed. On 2/1/13, at 8:45 a.m. the director of nursing (DON) verified the facility had no policies developed to address disposition of Fentanyl patches and other controlled medications. The DON also verified the pharmacy consultant had previously recommended the facility develop and adopt the policy of witnessed destruction of the Fentanyl patches, but indicated they had not been doing that. In addition, storage methods for these controlled medications awaiting final disposition had not been addressed.	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	Resident #27 is deceased. All residents with an infectious disease will have proper isolation		3/13/2013

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F 441	Continued From page 46 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain a	F 441	practices in place. This will include staff wearing a surgical mask when working within 3 feet of resident with a positive case of influenza. Will review present Infection Control Program. Will develop program which addresses collection, analysis, interpretation, and notification of findings to assist in the elimination, development and transmission of infections. This will include isolation precautions and how to proceed if a resident tests positive for influenza. This will be implemented and monitored by the DON by checking that appropriate precautions are in place for any resident with an infectious disease.		

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F 441	Continued From page 47 comprehensive infection control surveillance program for residents that included ongoing systematic collection, analysis, interpretation and notification of findings to assist in preventing the development and transmission of infections. This had the potential to affect all 60 residents in the facility. In addition, the facility failed to follow appropriate infection control practices related to transmission based precautions for 1 of 1 (R27) resident recently diagnosed with influenza A. Findings include: During interview with the director of nursing (DON) on 2/1/13, at 10:00 a.m., it was determined that the facility lacked pertinent policies/procedures related to the prevention of infection. The policies provided were also incomplete especially related to immunization of residents. Policies lacking (but not limited to) are: -Infection Prevention and Control Program -Surveillance - Transmission Based Precautions - Communicable Disease Reporting - Prevention and Control of Transmission of Infection - Multi Drug Resistant Organisms - Handling Linens Surveillance: The DON stated the staff complete an Infection Report on any residents who are diagnosed or show signs/symptoms of an infection. Some of the items collected include: site of infection, symptoms, diagnostic test, results, organism. There were 18 reports for the month of January	F 441			

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NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 48 2013, and 7 of those reports were not complete. The DON stated she files the reports and then quarterly will prepare an Infection Control (IC) Report for the Quality Assurance (QA) meeting. The information reported to the last two QA meeting on 12/20/12, and 9/24/12, failed to identify if there are any trends or patterns of infection. There is no tracking of infections, ongoing analysis or interpretation of the findings to prevent the spread of infection in the facility. Infection control: 9/24/12 4 gastrointestinal (GI) 4 Residents 7 upper respiratory 15 urinary tract infection (UTI) Infection Control: 12/20/12 8 upper respiratory 7 UTI 3 skin 0 GI 1 wound "No Ryme or Reason" documented under upper respiratory Transmission Based Precautions R27 was admitted to the facility on 8/3/12. He was hospitalized on 1/23/13 and returned 1/27/13 with diagnosis of Influenza A and pneumonia. When the DON was asked about any transmission based precautions, she stated the facility did not implement any precautions to protect staff, visitors or other residents. There was only signage on the front entrance which indicated they had a confirmed case of influenza in the facility.	F 441			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
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NAME OF PROVIDER OR SUPPLIER

GREEN PINE ACRES NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

**427 MAIN STREET NORTHEAST
MENAHA, MN 56464**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49	F 441		
F 520 SS=F	The DON was not able to respond to questions on how personal protective equipment would be made available when precautions were warranted. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct ongoing quality	F 520	At our next Quality Assurance Meeting which will be in March of 2013, we will ask the specialized therapy, dietary and pharmacy personnel to be present. We will develop an action plan related to care and survey issues from this year. We will post the minutes of the Quality Assurance Meeting in the breakroom where staff can easily access it. Prior to the Quality Assurance Meeting, the reports of staff and resident infection in the facility will be analyzed and this analysis will be reported and recorded at the QA Meeting. We will start analyzing infections on a monthly basis to look for trends in the facility and write a summary on this. This will be monitored by giving the summary to the administrator who will sign and date them.	3/13/2013

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NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page 50 assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility were aware of or should have been aware of that had the potential to adversely affect all 60 residents in the facility. Findings include: The facility QA program lacked a process for in depth analysis, improvement activities and action plans to address deficient practices in pain management, fall prevention, rehabilitative nursing and infection control monitoring and surveillance. Additionally, the QA committee did not consistently include input and participation by all contracted services or provide feedback to employees on activities of the committee. The director of nursing (DON) reported during interview on 2/1/13, at 9:00 a.m. the QA committee did have the required minimum membership and quarterly meetings but did not post or provide information to all staff related to QA meetings or projects with current action plans. In addition, the DON stated there was a record kept of resident and staff and infections and the statistics were gathered just before the QA meeting to report; however, no surveillance analysis was performed on an ongoing basis and problems with the facility infection control process had not been discussed during QA. The DON stated QA had discussed working on projects and develop action plans related to care and survey issues from the previous year, primarily falls. Fall statistics were reported in QA, but not analyzed, and action plans were not	F 520			

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F 520	Continued From page 51 developed. The decision was made during a QA meeting, however, to work on noise and HIPPA issues as primary projects and there were currently no action plans related to specific medical/care issues such as falls, pain or rehabilitative nursing. The DON stated there was no reporting or participation in QA by all contract providers such as specialized therapy, dietician and others. The pharmacy consultant "sometimes participated" and was available for phone conferencing. On 1/31/13 at 2:05 p.m. the DON was interviewed regarding falls and use of alarms in bed. The DON was notified that during random observations on 1/30/13, at 3:35 p.m. there were four residents who were observed in bed and the clip alarms were attached to the resident but the alarm itself was lying on the mattress near the pillow. When asked about placement of the clip alarm in bed, she stated that they have been monitoring to assure alarms are in place but did not check to make sure the alarms were secured. She verified the alarms should be attached to headboard or some other object. On 2/1/13, from 1:30-2:15 p.m., licensed practical nurse (LPN)-D stated she did not know much about the QA process or committee and did not know who was on it although the DON did refer to it sometimes during LPN meetings. Nursing assistants H and C (NA-H, NA-C) were not aware of the QA committee but did remember there were safety and other committees but had not seen any reports and were not aware of any action plans or projects the QA committee was working on or who was on the committee.	F 520			

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F 520	Continued From page 52 Registered nurse-B (RN-B) reported she had been at the facility over a year but knew, "A lot of nothing" about QA. The housekeeping supervisor also reported she did not know anything about the QA process or committee. The payroll/personnel training administrative staff reported on 2/1/13 at 2:30 p.m. there was not any initial or ongoing staff training included with orientation or required annual training materials that exposed staff to the QA committee or process at the facility.	F 520			

Addendum

F225

Where ever this plan of correction says "immediately, within 24 hours." The "within 24 hours" is to be removed.

When investigations are conducted after a report is sent in to state a thorough investigation will be done. This will include statements with NARs and LPN in the area or other staff who may have been present. .

Staff was educated on these changes with copies of Plan of Correction given to all RN's LPNs and TMAs.

Monitoring will be done by administrator.

Audit reports to be presented at Quality Assurance Meetings.

Addendum

F226

When investigations are done after a report is sent in to state, a thorough investigation will be made. This will include interviews with NAR, LPN and any other staff in the vicinity.

Staff was educated on this and will be given copies of the Plan of Correction as well as the addendum.

Monitoring will be done by administrator.

Audit reports to be presented at Quality Assurance Meeting.

JK

Addendum

F280

All residents will have a Dehydration Assessment done upon admission, quarterly and significant change. All assessments that indicate a resident is at high risk for dehydration will be randomly reviewed q 2 weeks for 2 months to see that appropriate interventions are being carried out. After two months, this will be done monthly.

All residents who are able to ambulate with the assist of staff are to be ambulated bid distance as tolerated. This is recorded in Point Click Care on the computer. A report will be run weekly to check how each resident is ambulating. If a resident is not walking, or walking very little this information is given in writing using a new Communication Form to both the primary RN and the Nursing Rehab RN.

DON will also randomly watch residents with ambulation.

Staff education was done on this by giving Plan of Correction.

Reports to be presented at Quality Assurance Meeting.

pk

Addendum

F281

All resident who need a temporary care plan will have one in place.

All residents who need a temporary care plan have been reviewed and have one in place.

Addendum

F309

All residents are assessed for pain upon admission, quarterly, with a significant change and prn. All residents who have pain issues will be on Pain Management especially residents with recent surgery, fractures or recent admissions.

All residents who have pain issues have been assessed and this is in place.

A new assessment was developed to assess positioning and seating in wheelchairs. This will be done by the primary RN quarterly and upon admission or with a significant change. If a new type of wheelchair is recommended, this will be given in writing to the RN in charge of Nursing Rehab. Staff was educated on this by putting it on Point Click Care and giving copies to all nurses of Plan of Correction.

Pain Management Meeting is held monthly where residents are reviewed who are on pain medications. It is discussed if the pain management is considered adequate. This information is then written up and given to all nurses.

DON will monitor by reviewing pain assessments that were done each month and within 7 days of new admissions; will review positioning assessments that were done each month.

Results will be reported at the Quality Assurance Meetings.

JK

Addendum

F311

All residents who are able to ambulate with assist of staff are to be ambulated bid as tolerated. This is recorded on Point Click Care. A report will be run weekly to check how each resident is ambulating as well as interviewing staff and watching residents ambulate. A decline in ambulatory ability will be conveyed to primary RN and to Nursing Rehab RN.

Staff was educated regarding this by giving copies of Plan of Correction to all nurses.

Results will be reported at Quality Assurance Meeting.

pk

Addendum

F323

Staff will be educated by placing information in the communication books and will also be informed in our next NAR meetings. Nurses will be educated by receiving copies of Plan of Correction.

All residents who are at risk for falls have been reviewed and all interventions are in place.

DON will monitor weekly for three months and then monthly to be sure they are secured to the bed.

AL

Addendum

F327

All residents will have dehydration assessment upon admission, quarterly and with a significant change done by primary RN. Appropriate interventions will be initiated.

Education of staff will be accomplished by giving Plan of Correction and Addendum to all nurses.

DON will monitor weekly for 2 months and then monthly after that to see that appropriate interventions are in place by doing random audits of charts.

Results will be reported at Quality Assurance Meeting.

Addendum

F431

DON will monitor this by checking the charting of the disposal of the Fentanyl Patches and that two nurses are charting when this is done. This will be monitored weekly times 3 months and then monthly.

Results will be reported at Quality Assurance Meetings.

JK

Addendum

F441

We did develop new infection policies especially on Influenza Like Illnesses and Gastroenteritis Outbreaks which talks about contact precautions. .

Copies of these will be given to all nursing staff and department heads. .

Will develop a way to do ongoing tracking of infections such as line listing of infections. Will consult with Michelle Dick, medical records consultant.

Administrator will monitor by checking that appropriate precautions are in place for any residents with an infectious disease.

Results to be reported at Quality Assurance Meetings.

22

Addendum

F520

Will bring all deficiencies to Quality Assurance Meetings noting that deficiency F323 is a repeat deficiency. . Will bring all results of audits to Quality Assurance Meetings.

Will start tracking infections using ongoing tracking such as line listing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building (1964 original building and 1969, 1996, 1999 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Green Pine Acres Nursing Home 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. Green Pine Acres Nursing Home was constructed in 5 different years. The original building was built in 1964, is 1-story with a partial basement and was determined to be Type II (111) construction. In 1969 an addition was constructed to the west of the original building, is 1-story, no basement and was determined to be Type II (111) construction. In 1996 the Administration building and connecting link were constructed to the south east corner of the original building. It is 1-story without a basement and was determined to be Type V (111) construction. This addition is separated from the existing facility by at least a 2-hour-rated fire barrier. In 1999 a laundry addition was constructed to the north west of the original building, is 1-story, without a basement. In 2004 a kitchen addition to the north west of the 1969 addition was constructed. It is 1-story without a basement and was determined to be Type II (111) construction. The building is divided into 4			K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

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

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K 000	Continued From page 1 smoke zones by 30 minute and 90 minute fire barriers. The entire facility is protected with an automatic sprinkler systems installed in accordance with NFPA 13 Standard for the installation of Sprinkler Systems 1999 edition with quick response heads in all areas except in hazardous areas where standard response heads are used. The facility has a fire alarm system with smoke detectors in the corridor system, in all common areas and is installed in accordance with NFPA 72 " The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored off site and has automatic fire department notification. The facility has a capacity of 65 beds and had a census of 59 at the time of the survey. This facility was surveyed as two separate buildings. The main building as existing, including the 1996 administration building and the 1999 laundry addition, with the 2004 kitchen addition as a separate building as new construction. The requirement at 42 CFR, Subpart 483.70(a) is MET.			K 000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245563		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - KITCHEN ADDITION B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 03 Kitchen Addition A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Green Pine Acres Nursing Home 03 Kitchen Addition 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 18 New Health Care. Green Pine Acres Nursing Home was constructed in 5 different years. The original building was built in 1964, is 1-story with a partial basement and was determined to be Type II (111) construction. In 1969 an addition was constructed to the west of the original building, is 1-story, no basement and was determined to be Type II (111) construction. In 1996 the Administration building and connecting link were constructed to the south east corner of the original building. It is 1-story without a basement and was determined to be Type V (111) construction. This addition is separated from the existing facility by at least a 2-hour-rated fire barrier. In 1999 a laundry addition was constructed to the north west of the original building, is 1-story, without a basement. In 2004 a kitchen addition to the north west of the 1969 addition was constructed. It is 1-story without a basement and was determined to be Type II (111) construction. The building is divided into 4 smoke zones by 30 minute and 90 minute fire			K 000			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464			
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K 000	Continued From page 1 barriers. The entire facility is protected with an automatic sprinkler systems installed in accordance with NFPA 13 Standard for the installation of Sprinkler Systems 1999 edition with quick response heads in all areas except in hazardous areas where standard response heads are used. The facility has a fire alarm system with smoke detectors in the corridor system, in all common areas and is installed in accordance with NFPA 72 " The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored off site and has automatic fire department notification. The facility has a capacity of 65 beds and had a census of 59 at the time of the survey. This facility was surveyed as two separate buildings. The main building as existing, including the 1996 administration building and the 1999 laundry addition, with the 2004 kitchen addition as a separate building as new construction. The requirement at 42 CFR, Subpart 483.70(a) is MET.			K 000			



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5853

February 21, 2013

Mr. Clair Erickson, Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, Minnesota 56464

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5563023

Dear Mr. Erickson:

The above facility was surveyed on January 28, 2013 through February 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rule. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Green Pine Acres Nursing Home

February 21, 2013

Page 2

and the Time Period For Correction.

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

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

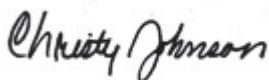
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 705 5th Street NW, Suite A, Bemidji, Minnesota 56601-2933. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Christy Johnson". The signature is written in a cursive, flowing style.

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00678	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 28, 29, 30, 31, and February 1, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.		

Minnesota Department of Health

TITLE

(X6) DATE

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00678	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified	2 255			

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2 255	Continued From page 2 quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility were aware of or should have been aware of that had the potential to adversely affect all 60 residents in the facility. Findings include: The facility QA program lacked a process for in depth analysis, improvement activities and action plans to address deficient practices in pain management, fall prevention, rehabilitative nursing and infection control monitoring and surveillance. Additionally, the QA committee did not consistently include input and participation by all contracted services or provide feedback to employees on activities of the committee. The director of nursing (DON) reported during interview on 2/1/13, at 9:00 a.m. the QA committee did have the required minimum membership and quarterly meetings but did not post or provide information to all staff related to QA meetings or projects with current action plans. In addition, the DON stated there was a record kept of resident and staff and infections and the statistics were gathered just before the QA meeting to report; however, no surveillance analysis was performed on an ongoing basis and problems with the facility infection control process	2 255			

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2 255	Continued From page 3 had not been discussed during QA. The DON stated QA had discussed working on projects and develop action plans related to care and survey issues from the previous year, primarily falls. Fall statistics were reported in QA, but not analyzed, and action plans were not developed. The decision was made during a QA meeting, however, to work on noise and HIPPA issues as primary projects and there were currently no action plans related to specific medical/care issues such as falls, pain or rehabilitative nursing. The DON stated there was no reporting or participation in QA by all contract providers such as specialized therapy, dietician and others. The pharmacy consultant "sometimes participated" and was available for phone conferencing. On 1/31/13 at 2:05 p.m. the DON was interviewed regarding falls and use of alarms in bed. The DON was notified that during random observations on 1/30/13, at 3:35 p.m. there were four residents who were observed in bed and the clip alarms were attached to the resident but the alarm itself was lying on the mattress near the pillow. When asked about placement of the clip alarm in bed, she stated that they have been monitoring to assure alarms are in place but did not check to make sure the alarms were secured. She verified the alarms should be attached to headboard or some other object. On 2/1/13, from 1:30-2:15 p.m., licensed practical nurse (LPN)-D stated she did not know much about the QA process or committee and did not know who was on it although the DON did refer to it sometimes during LPN meetings. Nursing assistants H and C (NA-H, NA-C) were not aware	2 255			

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2 255	Continued From page 4 of the QA committee but did remember there were safety and other committees but had not seen any reports and were not aware of any action plans or projects the QA committee was working on or who was on the committee. Registered nurse-B (RN-B) reported she had been at the facility over a year but knew, " A lot of nothing" about QA. The housekeeping supervisor also reported she did not know anything about the QA process or committee. The payroll/personnel training administrative staff reported on 2/1/13 at 2:30 p.m. there was not any initial or ongoing staff training included with orientation or required annual training materials that exposed staff to the QA committee or process at the facility. SUGGESTED METHOD FOR CORRECTION: The administrator could ensure that the Quality Assessment & Assurance (QA & A) members develop and implement appropriate plans of action to correct identified quality deficiencies. The QA & A members could set up a monitoring system to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 255			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	2 570			

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2 570	Continued From page 5 and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the plan of care to include identified interventions to reduce the risk of dehydration for 1 of 2 residents (R39) reviewed for dehydration; for 2 of 5 residents (R39, R6) for adaptive seating and positioning needs; and for 1 of 2 residents (R71) with rehabilitative nursing ambulation needs. Findings include: R39 did not have the care plan revised and updated to provide all relevant interventions for risk of dehydration and to provide optimal seating and positioning. R39 had diagnoses that included chronic liver disease, hemiplegia, hypertension, constipation, urinary incontinence, dementia and anxiety. The change of status Minimum Data Set (MDS) dated 7/25/12, and the most recent MDS (readmission) dated 11/9/12, identified R39 as cognitively intact, as requiring extensive assistance for eating/drinking, with limitation in range of motion on one side and diuretic use was noted. In addition, each MDS identified R39 as unsteady and unable to balance without physical assistance and as requiring extensive assistance	2 570			

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2 570	Continued From page 6 for mobility by wheelchair device. Neither MDS identified dehydration as a medical issue at the time of the assessment. R39 had been hospitalized from 11/1-11/5/12, for liver failure and was described in the discharge summary as moderately dehydrated and had received IV fluids during the hospital stay. The Care Area Assessment (CAA) for the 7/25/12, change of status MDS was triggered for risk of dehydration related to diuretic medication use, cerebrovascular accident, cognition/behaviors and weight change. The most recent facility dehydration risk assessment dated 1/7/13, identified R39 at high risk of dehydration and directed interventions of : fresh water in room twice daily, monitor weight and edema daily, notify physician of signs/symptoms of dehydration. R39's current care plan dated 1/5/10, for the problem of potential for dehydration noted the same interventions as identified in the recent 1/7/13, dehydration risk assessment and also directed staff to encourage water with and between meals, meds and at bedtime; however, this last intervention had not been added to the current nursing assistant (NA) care sheets. The NA care sheet noted only to provide fresh water in room twice a day and as needed. The facility policy dated 9/2012, for dehydration risk identified interventions for those residents at high risk was to include all interventions for low and moderate risk and also the following: monitor intake, offer liquids hourly when awake, offer other forms of liquids, total intake daily and notify RN if intake less than 1200 cc/24 hours.	2 570			

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2 570	Continued From page 7 These interventions in the policy for high risk were not included in R39's working care plan and were also not included in the current nursing assistant care sheets. The MDS nurse, registered nurse (RN)-D, verified on 1/31/13, at 1:00 p.m. R39 did not have the care plan revised for all the interventions directed in the current policy and that it was missed related to some nursing staffing changes at the time. Additionally, RN-D stated R39 was still at high risk, the care plan had been updated and ongoing monitoring should still be completed as per their policy. R39 also did not have the care plan revised to address individualized seating/positioning needs to enhance optimal positioning that enhanced comfort and functionality. The 7/25/12, change of status MDS, CAA for activities of daily living noted R39 had contractures, utilized a wheelchair and could propel the wheelchair somewhat. The most recent occupational therapy (OT) assessment dated 10/9/12, noted poor sitting balance, pain and weakness and treatment was directed toward improving function and wheelchair management to enable R39 to propel wheelchair throughout the facility with right side extremities. Unit RN-B reported on 2/1/13, at 9:30 a.m. the first documentation that indicated R39 had been moved to the Homecrest (type of geri) chair was a nurses note on 12/4/12, that stated: Up in Homecrest chair, no complaints of pain. There	2 570			

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2 570	Continued From page 8 were scattered entries in the nurses notes since December that indicated seating was in the Homecrest chair and the care plan dated 1/8/13 noted the Homecrest chair use; however, it did not include all interventions that enhanced optimal positioning and comfort. The care plan did note the feet should be supported in the chair, but did not address the arm position or ankle/leg position or how and when to adjust the foot supports on the chair with or without the use of the ankle/foot brace (AFO). During the survey on 1/28/13, at 5:08 p.m. R39 was observed seated in a Homecrest geri-chair that she was unable to self propel and required one staff for movement. The Homecrest chair had an adjustable foot plate that did not support either foot and created inversion and plantar flexion of both feet, including the left foot that was partially supported by a loose AFO brace. The left upper extremity and hand was not supported by padding or a pillow and was wedged against the left thigh. R39 stated she was not comfortable in the chair and the left arm was painful. R39 was moved into the dining room at 5:38 p.m. and did have a small pillow under the left hand; however, the feet were still not supported. R39 was again observed in the dining room on 1/31/13, at 8:00 a.m. in the Homecrest chair, but without the AFO on the left foot, just wearing a sock. The foot was plantar flexed and inverted and unsupported by the adjustable foot rest. RN-B reported on 2/1/13, at 9:30 a.m. there had not been another occupational therapy assessment referral completed when the chair was switched and only verbal discussions with the OT assistant had occurred, but positioning	2 570			

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2 570	Continued From page 9 specifics for the left side extremities were not documented in the nurses notes or the care plan. R6 did not have the care plan revised to address individualized seating/positioning needs to enhance optimal positioning that enhanced comfort and functionality. R6 was noted to have a wheelchair that did not support and allow the feet to fully contact the floor for mobility/comfort/safety. R6 had diagnoses that included Alzheimer's disease and dementia, generalized pain, pyogenic arthritis, osteoporosis, and generalized osteoarthritis involving multiple sites. The annual MDS dated 9/4/12, and quarterly MDS dated 11/27/12, identified R6 with cognitive independence, extensive assistance of one staff for mobility by wheelchair and impaired range of motion of all four upper and lower extremities. The CAA for the 9/4/12, MDS for activities of daily living noted limitations from arthritis and noted assistance was needed to propel the wheelchair. R6 was observed repeatedly during the survey, sitting in the wheelchair with only the toes and forefoot contacting the floor surface. Random observations were documented on 1/28/13, at 6:30 p.m. and 7:30 p.m., 1/29/13, at 11:20 a.m. and 11:45 a.m., 1/31/13, at 2:00 p.m. with R6 as she attempted to propel the wheelchair with minimal effectiveness using the stocking feet with contact only with the toes/forefoot and some attempt using the hands on the wheels. The toes were hyperextended at the metatarsal joints where R6 had foot deformities from arthritis.	2 570			

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2 570	Continued From page 10 During interview with R6 on 1/28/13 at 6:30 p.m. she reported some chronic foot discomfort and stated, "My feet are all crippled up and I can't wear shoes." R6's care plan identified a focus area for mobility and had an intervention that noted: Can propel wheelchair when she desires to; assist of one to go to the rehab room (long distances). A foam cushion was noted in the wheelchair. The care plan also noted to remind the resident to put hands on lap before staff moves wheelchair and spoke covers on wheels to prevent bruising. The certified occupational therapy assistant (COTA) verified on 1/30/13, at 12:00 p.m., R6 was already in a low chair, but the chair could be lower to provide better floor contact. The COTA also stated no seating referrals had been requested by OT for R6's seating issues. The COTA also stated there had been no training for nursing staff on wheelchair seating and positioning issues or what to look for to refer and added there had been "lots of turnover in nursing staff." RN-B reported during interview on 2/1/13, at 9:30 a.m. R6's care plan had not been revised to include interventions for proper seating, lower wheelchair, or foot contact with the floor for mobility. R71's care plan related to ambulation had not been revised. R71's diagnoses included dementia. The quarterly MDS dated 1/23/13, identified R71 as cognitively impaired and as requiring assistance with ambulation. The Care Area Assessment (CAA) regarding falls dated 10/31/12, indicated	2 570			

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2 570	Continued From page 11 R71 had impaired balance requiring assistance of staff for transfers and ambulation. The CAA also indicated R71 was on a walking list and did work with nursing rehab though often refused. The revised plan of care (POC) dated 1/15/13, identified R71 ambulated independently with a walker during the day and stand by assist from staff in room at night at times. The POC indicated nursing rehab was working with R71 on balance. The current nursing assistant (NA) resident care sheet for R71 indicated starting 1/23/13, R71 was to be walked to meals. On 1/31/13, at 8:35 a.m. R71 was observed sitting in wheelchair across from the nurses desk. At 10:00 a.m. NA-C stated R71 did not walk independently and licensed practical nurse (LPN) -E stated R71 was no longer independent with ambulation, and started using a wheel chair on 1/17/13. At 11:10 a.m. NA-C stated R71 could not walk and did not walk to meals. NA-C stated she was not unaware of R71 needing to walk to meals and was not aware it was on R71's care sheet. At 11:45 a.m. RN-A stated she was unaware R71 was not walking as indicated on R71 NA care sheet. RN-A stated R71 was to be walking to all meals with the NAs. RN-A stated R71's ambulation program was lacking from the R71's current POC. On 1/31/13, at 1:35 p.m. R71 was observed being ambulated with a transfer belt and front wheel walker by NA-C and NA-D, with NA-E pushing a	2 570			

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2 570	Continued From page 12 wheelchair behind R71. R71 was able to ambulate approximately 25 feet, when her knees started to buckle and she was placed in the wheelchair. On 2/1/13, at 9:50 a.m. NA-H sated R71 was having a hard time walking and requiring two staff to transfer. NA-H stated one and a half weeks ago R71 was independent with her ambulation. On 2/1/13, at 2:30 p.m. RN-B stated R71's POC needed to be revised. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 570			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830			

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2 830	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary care and services for 1 of 1 resident (R82) reviewed who required pain management interventions and for 2 of 5 residents (R39, R6) utilizing wheelchairs that were not provided optimal seating and positioning. In addition, the facility failed to ensure 1 of 1 resident (R63) who was at high risk for falls had alarms properly secured and functioning per manufacturers instructions. Findings include: R82 consistently had moderate to severe pain related to pressure ulcers on coccyx, right inner heel, outer edge of left foot, and left hip, which was not relieved with Tylenol (a pain medication recommended for mild to moderate pain) 650mg every four hours as needed. R82 was admitted to the facility on 1/26/2013 with pressure ulcers on coccyx, right inner heel, outer edge of left foot, and left hip. R82 had diagnoses that included anemia, gastroenteritis and colitis. An initial Minimum Data Set (MDS) was not completed at the time of the survey. The medical record did not indicate R82's cognitive status. The history and physical dated 1/25/2013, indicated R82 had fallen at home three to four days prior to admission to the hospital and was crawling around on her hands and knees and was unable to bear weight. The history and physical also indicated R82 had apparently fallen and	2 830			

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2 830	Continued From page 14 broken her left hip within the last year which had been repaired. In addition, R82 was noted to have chronic weakness and consumed two to three drinks of alcohol per day. During observation on 1/28/2013, at 3:56pm, R82 exhibited a pained facial expression. During cares on 1/29/2013, R82 verbally complained of pain and said, "Oww, Oww" when licensed practical nurse (LPN)-E lifted right foot and then left foot and applied heel protectors to both feet. On 1/30/13, at 7:02 a.m. trained medication aide (TMA)-A was observed to provide treatment to the pressure ulcer on the left outer heel. R82 stated she had pain "all over" at that time. On 1/31/2013, at 8:28 a.m., R82 verbally complained of pain and said, "Oww, Oww " and had a grimaced facial expression when TMA)-A gently raised the right foot to apply gauze to a pressure ulcer, raised left foot to apply heel protectors. She continued to have complaints of pain while TMA-A repositioned R82 to her right side to provide treatment to left hip pressure ulcer. TMA-A sprayed colloidal silver to left hip pressure ulcer, repositioned to her left side to provide pressure ulcer treatment to coccyx and sprayed colloidal silver on the pressure ulcer on the coccyx. R82 verbalized pain and had facial grimacing during the procedure. The physician's orders dated 1/26/2013, indicated Tylenol 650 (milligrams) mg every four hours as needed was the only pain medication ordered for R82's pain. A pain management progress note dated 1/27/2013, indicated pain level was 6-7 and R82 had stated, "Pain comes and goes, but never	2 830			

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2 830	Continued From page 15 leaves all the way." A progress note dated 1/27/2013, indicated R82 rated pressure ulcer pain in heels, coccyx and left hip at seven out of ten and R82 refused pain medication (Tylenol), on all three shifts. A skin/wound progress note dated 1/27/13, documented R82 complained of moderate pain when dressing wounds. A pain management progress note dated 1/28/2013, indicated R82 complained of pain stating, "It's all over." R82 rated pain level at an eight out of ten and gave a verbal description of the pain. R82 rated the pain at a three out of ten when she received Tylenol 650 mg every four hours as needed, and rated the pain at an eight out of ten when she did not accept the Tylenol. During an interview on 1/31/2013, at 1:33 p.m., RN-C stated R82 was on a pain monitoring system in which the charge nurse monitored R82's pain every shift and wrote a narrative note if R82 complained of pain and described the pain. RN-C reviewed the progress notes from 1/26/2013 to 1/31/2013 and verified R82 had complained of pain all over and rated the pain a seven or eight out of ten on numerous shifts. RN-C stated R82 had routinely refused the Tylenol but had routinely accepted a physician's order for 15 milliliters (ml) of whiskey each evening. RN-C stated she was concerned about seeking an alternative pain medication because she was unsure how the pain medication would affect R82's consumption of whiskey each evening. RN-C verified R82 had significant, routine pain without relief from the Tylenol 650 mg every four hours. RN-C also stated she was unsure why the Hydrocodone (narcotic) was discontinued at the time of admission to the facility from the hospital. RN-C verified she had not further assessed R82's pain and had not contacted the physician for	2 830			

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2 830	Continued From page 16 possible alternative pain management for R82 since date of admission. RN-C stated she would inquire to the physician about a better pain management for R82. R39 was not consistently provided services to promote optimal seating and positioning to enhance comfort and functionality. The 7/25/12, Care Area Assessment (CAA) for activities of daily living noted R39 had contractures, utilized a wheelchair and could propel the wheelchair somewhat. The most recent readmission MDS dated 11/12/12, noted R39 required extensive assistance of one staff for mobility by wheelchair and had frequent pain rated five (1-10 scale) that also affected sleep. The most recent occupational therapy (OT) assessment dated 10/9/12 noted poor sitting balance, pain and weakness and treatment was directed toward improving function and wheelchair management to enable R39 to propel wheelchair throughout the facility with right side extremities. Unit registered nurse (RN)-B reported on 2/1/13, at 9:30 a.m. the first documentation that indicated R39 had been moved to the Homecrest (type of wheelchair/geri-chair) chair was a nurses note on 12/4/12 that stated: Up in Homecrest chair, no complaints of pain. There were scattered entries in the nurses notes since December that indicated seating was in the Homecrest chair. The care plan dated 1/8/13, noted the Homecrest chair use; however, it did not include all interventions that enhanced optimal positioning and comfort. The care plan did note the feet	2 830			

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2 830	Continued From page 17 should be supported in the chair, but did not address the arm position or ankle/leg position or how and when to adjust the foot supports on the chair with or without the use of the ankle/foot brace (AFO). A health status progress noted dated 1/8/13 noted R39's right foot had started to develop foot drop; R39 transferred with Hoyer lift to Homecrest chair and no longer bore weight. It noted staff was instructed to ensure resident's feet were resting on the foot rest and was adjustable. Nursing rehab had reported R39 had more left hand discomfort with extension. The left foot was noted to not fit well into the AFO and a new brace was to be obtained. During the survey on 1/28/13 at 5:08 p.m. R39 was observed seated in a Homecrest geri-chair that she was unable to self propel and required one staff for movement. The Homecrest chair had an adjustable foot plate that did not support either foot and created inversion and plantar flexion of both feet, including the left foot that was partially supported by a loose AFO brace. The left upper extremity and hand was not supported by padding or a pillow and was wedged against the left thigh. R39 stated she was not comfortable in the chair and the left arm was painful. R39 was moved into the dining room at 5:38 p.m. and did have a small pillow under the left hand; however, the feet were still not supported. R39 was again observed in the dining room on 1/31/13 at 8:00 a.m. in the Homecrest chair, but without the AFO on the foot, just wearing a sock. The foot was plantar flexed and inverted and unsupported by the adjustable foot rest. RN-B also reported on 2/1/13 at 9:30 a.m. there	2 830			

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2 830	Continued From page 18 had not been another occupational therapy assessment referral completed when the chair was switched and only verbal discussions with the OT assistant had occurred, but positioning specifics for the left side extremities were not documented in the nurses notes or the care plan. R6's wheelchair did not support and allow the feet to fully contact the floor for mobility/comfort/safety. R6 had diagnoses that included Alzheimer's disease and dementia, generalized pain, pyogenic arthritis, osteoporosis, and generalized osteoarthritis involving multiple sites. The annual MDS dated 9/4/12, and quarterly MDS dated 11/27/12, identified R6 with cognitive independence, extensive assistance of one staff for mobility by wheelchair and impaired range of motion of all four upper and lower extremities. The CAA for the 9/4/12, MDS for activities of daily living noted limitations from arthritis and noted assistance was needed to propel the wheelchair. During interview with R6 on 1/28/13, at 6:30 p.m. she reported some chronic foot discomfort and stated, "My feet are all crippled up and I can't wear shoes." R6 was noted at that time to have feet dangling and not contacting the floor when in the wheelchair. R6 stated she did not have legrests for the chair. R6 was observed repeatedly during the survey, sitting in the wheelchair with only the toes and forefoot contacting the floor surface. Random observations were documented on 1/28/13, at 6:30 p.m. and 7:30 p.m., 1/29/13, at 11:20 a.m.	2 830			

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2 830	Continued From page 19 and 11:45 a.m., and 1/31/13, at 2:00 p.m. with R6 as she attempted to propel the wheelchair with minimal effectiveness using the stocking feet with contact only with the toes/forefoot and some attempt using the hands on the wheels. The toes were hyperextended at the metatarsal joints where R6 had foot deformities from arthritis. During the 1/29/13, 11:20 a.m. observation, R6 was unable to get sufficient foot traction to propel the chair, did not use the arms on the wheels, and stated, "Help me." A staff then pushed R6 into the dining room and up to the table. R6 was observed 1/31/13, at 10:05 a.m. while pushed to the activity room for an activity by NA-A. The staff did not apply the legrests to the chair before moving R6 from her room to the activity room. When R6 was turned sharply to position under the table, the front wheel swiveled and struck R6's unsupported right foot/ankle that caused discomfort and caused R6 to loudly cry out, "Ouch, Hey." At 2:00 p.m. NA-A was asked if R6 had legrests in her room that could be applied to the chair for transport. A pair of legrests for the wheelchair were located in R6's closet. NA-A reported the R6 did not like to use the legrests. R6's care plan dated 12/5/12, identified a focus area for mobility and had an intervention that noted: Can propel wheelchair when she desires to; assist of one to go to the rehab room (long distances). A foam cushion was noted in the wheelchair. The care plan also noted to remind the resident to put hands on lap before staff moves wheelchair and spoke covers on wheels to prevent bruising. The occupational therapy assistant (COTA)	2 830			

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2 830	Continued From page 20 verified on 1/30/13, at 12:00 noon, R6 was already in a low chair, but the chair could be lower to provide better floor contact. The COTA also stated no seating referrals had been requested by OT for R6's seating issues. The COTA also stated there had been no training for nursing staff on wheelchair seating and positioning issues or what to look for to refer and added there had been "lots of turnover in nursing staff." The occupational therapist (OT-A) reported during telephone interview on 1/31/13, at 9:15 a.m. nursing staff and the COTA were to do screening for seating and positioning needs and most referrals to OT were for residents who came from the hospital. OT-A could only recall one referral for seating and that was related to a power chair. OT-A stated he had not done any training for staff on seating/positioning, but verified the seating conditions noted with R39 and R6 definitely had positioning needs that should be addressed. OT-A suggested OT-B be contacted because they were at the facility more often. OT-B was contacted on 1/31/13 at 9:30 a.m. and she also reported screening for seating needs was done by nursing/COTA. OT-B could not recall getting any referrals to assess seating for R6 or R39 and was not aware of mobility issues for R6 or that R39 had been moved to a Homecrest chair. RN-B reported during interview on 2/1/13 at 9:30 a.m. R6's care plan had not been revised to include interventions for proper seating or foot contact with the floor for mobility and a referral to therapy of OT had not been completed and there were no policies that could be located that identified specific instructions for referral to	2 830			

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2 830	Continued From page 21 therapy for positioning or other issues. RN-B stated most of the issues were verbally discussed with available facility staff but not referred to therapy or documented in the record. R63 had 14 falls from 2/1/12 to 1/25/13. The wheelchair and bed sensor alarms were not always functioning at the time of the fall to alert staff of attempts to self transfer for 8 of the falls. In addition, the clip alarm was not being implemented while in bed according to manufacturers instructions which rendered it inoperable. R63 had diagnoses that included a history of falls, Alzheimer's disease, psychophysical visual disturbance, transient ischemic attack (mini stroke or episode of neurologic dysfunction), osteoporosis and a former closed fracture of the 1-4 cervical bones. The quarterly Minimum Data Set (MDS) dated 10/29/12, indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 5, two falls since the prior MDS dated 8/7/12, total dependence of two for bed mobility, extensive assistance for transfers, dressing, eating, toileting and personal hygiene and wheelchair mobility. The MDS indicated R63 was non-ambulatory. R63 also had functional limitations in range of motion in upper and lower extremities on both sides. The Care Area Assessment (CAA) for falls, dated 5/23/12 indicated R63 had been identified a fall risk with a history of multiple falls. The CAA indicated R63 tends to crawl out of bed or chair and does not always alert staff to needs.	2 830			

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2 830	Continued From page 22 The care plan dated 6/30/11, and revised 1/22/13, directed caregivers to check the batteries in the sensor pads on the wheelchair and bed. In addition, the care plan directed, "nursing to check to ensure alarms are hooked up once resident is in bed. To assure alarms are in place, turned on and functioning properly, on each shift when he was in bed." The fall risk assessments dated 1/21/13, 10/29/12, 8/6/12, 5/14/12, 2/6/12 and 11/25/11, consisted of multiple falls, crawling out of bed or wheelchair, and each assessment identified R63 at high risk for falls. Review of the facility's fall investigations timeline and summary are as follows: - 1/6/12 at 7:50 a.m. found in bedroom with knees on mat and leaning upper body on the bed. The tab alarm was connected to the resident, alarm not sounding. Noted tab alarm attached on his right side and wanted it attached on the left side. -2/1/12 at 7:20 p.m. found on knees in his bedroom. He had removed the wheelchair tray and sensor alarm did not sound. -3/22/12 at 8:25 P.M. a witnessed attempt to get out of wheelchair and slid to floor. The wheelchair alarm sounded, the TAB alarm was not sounding. Location was south hallway. -5/4/12 at 2:30 a.m. found on knees in bedroom with alarm sounding. -5/19/12 at 11:35 p.m. found sitting on the floor in his bedroom. The TAB (product name) alarm was still connected but too close to sound the	2 830			

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2 830	Continued From page 23 alarm. The bed alarm did not sound. -5/24/12 at 9:50 a.m. found on knees in bedroom with upper body on the bed. No alarms sounded. The alarm clip was on the gown and alarm not sounding. -5/25/12 at 2:35 a.m. found on knees in bedroom with TAB alarm in his hand and upper body leaning on the bed. No alarms sounded. -6/5/12 at 2:30 p.m. sliding from wheelchair to the floor was witnessed and an alarm was sounding. -7/14/12 at 10:00 p.m. found on floor in his bedroom laying on 1/2 of the alarm, which was sounding. -8/29/12 at 9:00 p.m. sliding out of wheelchair, sat on wheelchair footrests. -8/30/12 at 9:00 p.m. found on floor in bedroom with no alarm sounding. The bed alarm was not hooked up. The TAB alarm was clipped to the resident but the box was in the bed, not alarming. -10/16/12 at 9:45 p.m. found on the floor mat in his bedroom with the alarm sounding. -1/25/13 at 12:35 a.m. found on floor by the sink. The TAB alarm was attached to the gown, but the box was not sounding. The bed alarm was blinking but the cord was not inserted into the alarm box, so was not sounding. The resident sustained a bruise to the left elbow. The new intervention was for "Once resident is in bed, check to make sure alarms are in place, turned on and functioning properly. Remind nursing staff to check resident every hour once in bed."	2 830			

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2 830	Continued From page 24 On 1/30/13 at 7:12 a.m. R63 was near the nursing desk in a wheelchair with an acrylic tray in front of him. At 9:55 a.m. nursing assistant (NA)-C and NA-F were going to transfer R63 to a commode in his room. NA-D entered the room at 10:04 a.m. with a mechanical assist lift to transfer him from wheelchair to commode. R63 had the ability to grasp his hands on the lift bars and did so. NA-F, NA-C and NA-D were unable to provide information related to R63's fall and stated the nurses do that. The NA's did explain the alarms are placed in the cloth bag that hangs at the back of the wheelchair and when he was in bed the alarms were also in the bags for the TAB alarm clipped to his clothing or the bed sensor alarm. On 1/30/13, at 1:40 p.m. R63 was observed to repeat a transfer from the commode to the bed. Bilateral leg braces were placed, a spacer pillow between his knees, a supportive neck pillow, floor mat next to the low bed, a bed sensor alarm and a TAB alarm clipped on the left shoulder of his shirt. Both alarms were also used while R63 was in the wheelchair. At 3:30 p.m. R63 was observed in bed on his back. The TAB (clip) alarm was clipped to his shirt on left shoulder. However, the alarm was lying on mattress next to pillow not affixed to permanent object. NA-G was interviewed at the time regarding the alarm. She verified observations and stated they (NAs) do not attach the alarm box to anything and demonstrated how the magnet comes off the alarm box when pulled. NA-G added that they make sure the alarm is clipped to the opposite side R63 is lying so he does not remove. On 1/31/13, at 7:30 a.m. licensed practical nurse (LPN)-D, stated the night shift staff would get R63 out of bed and dressed if he was restless. LPN-D stated R63 will rise at 4:00 a.m. or anytime of	2 830			

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2 830	Continued From page 25 day. On 1/31/13 at 1:45 p.m. NA-C stated R63 does have the strength in arms to push the acrylic tray off the wheelchair "with a big bang." The tray slides forward to come off the wheelchair and he will push on it when he gets restless. NA-C further explained R63 cannot get back into bed or attempt to stand if he is on his knees on the floor mat by the bed. On 1/31/13, at 11:15 a.m. the registered nurse (RN)-C stated any resident fall on the afternoon or night shift is reported the next day. As the RN she reviewed all falls and does the investigation and follow-up. RN-C stated R63 used a TAB alarm in the wheelchair and also a sensor alarm. She stated, "It sounds depending on how they clip it. It should be positioned on the opposite side of the alarm, no specific area on the shirt. The alarm is in a bag strapped on the back of the wheelchair. He also used a slide assist pad in the wheelchair to prevent sliding out of the wheelchair." In addition, RN-C stated there is a Velcro bag for the sensor alarm which hangs or clips on the mattress or headboard. At 11:56 a.m. RN-C stated before fall interventions are determined the interdisciplinary team discussed the falls report in the morning meetings. The falls committee also meets monthly to review resident falls. RN-C was questioned about the placement of the TAB alarm when in bed and verified that the alarm may be inoperable if it is not attached to a permanent location. She added that she was not aware the staff were not resting the alarm on the mattress versus affixing to headboard. RN-C verified the TAB alarm would not be effective if it fell along with the resident. The length of the alarm string	2 830			

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2 830	Continued From page 26 needs to be long enough to get up to the Velcro strip on the headboard of the bed. On 1/31/13 at 2:05 p.m. the director of nursing (DON) was interviewed regarding R63's falls and interventions. She stated R63 did not ambulate since admission in 2011. The acrylic tray intervention for falls was implemented in 4/12, as he tries to get out of wheelchair. Both sensor and clip alarms while in his low bed as he tried to crawl out of bed if restless. The DON added the falls committee discussed every resident fall, what happened and analyzed what was going on. When asked about placement of the TAB alarm in bed, she stated that they have been monitoring to assure alarms are in place but did not check to make sure the alarms were secured. She verified the alarms should be attached to headboard or some other object. The DON stated the facility lacked an alarm policy. The manufacturer's instructions for the AliMed IQ Duo Plus Alarm #711290 alarm (utilized by R63) indicated, read entire instruction sheet before using alarm, failure to do so may result in injury or death to a person in your care. The manufacturer instructions addresses the use of hanging straps to secure the alarm. · Remove alarm unit from holster. · Remove plastic wrap from cleanable strap. · Unclip strap by removing loose end from buckle strap. · Wrap strap around slots in back of holster. · Once alarm strap is inserted properly, slide buckle back onto strap. · Wrap plastic strap around arm of chair or rail of bed and click buckle shut. · Adjust size of strap around chair or bed by	2 830			

Minnesota Department of Health
STATE FORM

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2 915	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide planned ambulation services for 1 of 2 residents (R71) in the sample who received ambulation services. Findings include: R71 did not receive ambulation services according to her assessed needs. R71's diagnoses included dementia. The quarterly Minimum Data Set (MDS) dated 1/23/13, identified R71 as cognitively impaired and as requiring assistance with ambulation. The Care Area Assessment (CAA) regarding falls dated 10/31/12, indicated R71 had impaired balance requiring assistance of staff for transfers and ambulation. The CAA also indicated R71 was on a walking list with nursing rehab although often refused. The 1/14/13, quarterly fall assessment indicated R71 was to ambulate with a walker and nursing rehab to work on balance. The plan of care (POC) dated 1/15/13, identified R71 ambulated independently with a walker during the day and with stand by assist from staff in room at night at times. The POC indicated nursing rehab was working with R71 on balance. The current nursing assistant (NA) resident care sheet for R71 indicated starting 1/23/13, R71 was to be walked to meals.	2 915			

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2 915	Continued From page 29 Review of the 1/13, nursing ambulation sheet indicated: The day shift had ambulated R71 two out of 18 opportunities, and documented "4" and "8" feet. Five out of these 18 opportunities had been documented as "N/A" and two out of these 18 opportunities had been documented as "RR (resident refused)." The evening shift had ambulated R71 one out of 8 opportunities and documented "10" feet. Seven out of the 9 opportunities had been documented as "RR" and 1 as "0". On 1/31/13, at 8:35 a.m. R71 was observed sitting in wheelchair across from the nurses desk. At 10:00 a.m. NA-C stated R71 did not walk independently and licensed practical nurse (LPN) -E stated R71 was no longer independent with ambulation, and had started using a wheelchair on 1/17/13. At 11:10 a.m. NA-C stated R71 could not walk and did not walk to meals. NA-C stated she was not unaware R71 was to walk to meals and was not aware it was on R71's care sheet. At 11:45 a.m. registered nurse (RN)-A stated she was unaware R71 was not walking as indicated on the NA care sheet. RN-A stated R71 was to walk to all meals with the NAs. RN-A stated R71's ambulation program was lacking from the POC. On 1/31/3, at 1:35 p.m. R71 was observed being ambulated with a transfer belt and front wheel walker by NA-C and NA-D, with NA-E pushing a wheelchair behind. R71 was able to ambulate	2 915			

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2 915	Continued From page 30 approximately 25 feet, and then her knees started to buckle and she was placed in the wheelchair. At that time, NA-C stated that the night before, she had attempted to ambulate R71 from her bed to the bathroom and R71's knees started to buckle, so she sat R71 back into her wheelchair. NA-C, NA-D, and NA-E stated they thought PT (physical therapy) should evaluate R71 because they felt it was not safe to ambulate R71. On 2/1/13, at 9:50 a.m. NA-H stated R71 was having a hard time walking and required two staff to transfer. NA-H stated a week and a half ago, R71 had been independent with her ambulation, however, she had been sick with the flu. On 2/1/13, at 2:30 p.m. RN-B stated a referral had been sent to PT to have R71's ambulation evaluated. On 2/1/13, at 2:15 p.m. RN-C stated if nursing is ambulating a resident, ambulation will be added to the plan of care. On 2/1/13, at 2:25 p.m. the director of nursing (DON) stated R71 ambulation should be reviewed on a weekly basis and if the resident was refusing or ambulation was not being offered, the resident would be re-assessed. The DON stated the facility had lacked enough RNs to be able to do the task. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with	2 915			

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2 915	Continued From page 31 ambulation. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 915			
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services according to facility policy to address hydration needs for 1 of 2 residents (R39) in the sample who demonstrated signs and symptoms of dehydration. Findings include: R39 had diagnoses that included chronic liver disease, constipation, urinary incontinence, and dementia. The change of status Minimum Data Set (MDS) dated 7/25/12, and the most recent MDS (readmission) dated 11/9/12, identified R39 as cognitively intact, and as requiring extensive assistance for eating/drinking. Limitations in range of motion on one side and diuretic use was also noted. Neither MDS identified dehydration as a medical issue at the time of the assessments.	2 940			

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2 940	Continued From page 32 R39 had been hospitalized from 11/1-11/5/12, for liver failure and was described in the discharge summary as moderately dehydrated with dry oral mucosa and had received intravenous (IV) fluids during the hospital stay for that condition. The Care Area Assessment (CAA) for the 7/25/12, was triggered for risk of dehydration related to diuretic medication use, cerebrovascular accident, cognition/behaviors and weight change. The most recent facility dehydration risk assessment dated 1/7/13, identified R39 at high risk of dehydration and directed interventions of : fresh water in room twice daily, monitor weight and edema daily, and notify physician of signs/symptoms of dehydration. R39's current care plan dated 1/5/10, for the problem of potential for dehydration noted the same interventions as identified in the recent 1/7/13, dehydration risk assessment and also directed staff to encourage water with and between meals, meds and at bedtime. However, this intervention had not been added to the current nursing assistant (NA) care sheets. The NA care sheet noted only to provide fresh water in room twice a day and as needed. During interview with R39 on 1/28/13, at 5:19 p.m. she reported she was thirsty and requested water to drink. There was a glass of water observed across the room on the dresser/sink area. R39 was also noted to have a dry mouth and cracking of the lips and breathed with the mouth open. The policy dated 9/2012, for dehydration risk, identified interventions for those residents at high	2 940			

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2 940	Continued From page 33 risk was to include all interventions for low and moderate risk and also the following: monitor intake, offer liquids hourly when awake, offer other forms of liquids, total intake daily and notify RN (registered nurse) if intake less than 1200 cc/24 hours. These interventions in the policy for high risk were not included in R39's working care plan and were also not included in the current nursing assistant care sheets. The MDS nurse, RN-D, verified on 1/31/13, at 1:00 p.m. R39 did not have her care plan revised for all the interventions for dehydration as directed in the current policy and had been missed related to some earlier nursing staffing changes. Additionally, RN-D stated R39 was still at high risk, the care plan had been updated that day and ongoing intake monitoring should still be completed as per their policy. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise policies and procedures for evaluating residents at risk for dehydration and provide additional training to staff. A designated staff could monitor the system. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 940			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection	21375			

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21375	Continued From page 34 control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain a comprehensive infection control surveillance program for residents that included ongoing systematic collection, analysis, interpretation and notification of findings to assist in preventing the development and transmission of infections. This had the potential to affect all 60 residents in the facility. In addition, the facility failed to follow appropriate infection control practices related to transmission based precautions for 1 of 1 (R27) resident recently diagnosed with influenza A. Findings include: During interview with the director of nursing (DON) on 2/1/13, at 10:00 a.m., it was determined that the facility lacked pertinent policies/procedures related to the prevention of infection. The policies provided were also incomplete especially related to immunization of residents. Policies lacking (but not limited to) are: -Infection Prevention and Control Program -Surveillance - Transmission Based Precautions - Communicable Disease Reporting - Prevention and Control of Transmission of Infection - Multi Drug Resistant Organisms - Handling Linens Surveillance:	21375			

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21375	Continued From page 35 The DON stated the staff complete an Infection Report on any residents who are diagnosed or show signs/symptoms of an infection. Some of the items collected include: site of infection, symptoms, diagnostic test, results, organism. There were 18 reports for the month of January 2013, and 7 of those reports were not complete. The DON stated she files the reports and then quarterly will prepare an Infection Control (IC) Report for the Quality Assurance (QA) meeting. The information reported to the last two QA meeting on 12/20/12, and 9/24/12, failed to identify if there are any trends or patterns of infection. There is no tracking of infections, ongoing analysis or interpretation of the findings to prevent the spread of infection in the facility. Infection control: 9/24/12 4 gastrointestinal (GI) 4 Residents 7 upper respiratory 15 urinary tract infection (UTI) Infection Control: 12/20/12 8 upper respiratory 7 UTI 3 skin 0 GI 1 wound " No Ryme or Reason" documented under upper respiratory Transmission Based Precautions R27 was admitted to the facility on 8/3/12. He was hospitalized on 1/23/13 and returned 1/27/13 with diagnosis of Influenza A and pneumonia. When the DON was asked about any transmission based precautions, she stated the facility did not implement any precautions to	21375			

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21375	Continued From page 36 protect staff, visitors or other residents. There was only signage on the front entrance which indicated they had a confirmed case of influenza in the facility. The DON was not able to respond to questions on how personal protective equipment would be made available when precautions were warranted. Suggested Method of Correction: The administrator or designee could review policy and procedures regarding infection control. Facility could educate staff on policy and procedures and develop a monitoring system to ensure compliance with surveillance analysis and trending was completed. Time Period for Correction: Twenty one (21) days.	21375			
21410	MN Rule 4658.0815 Subp. 1 Employee Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Information bulletin 09-02 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4658.0815 Subpart 1 Employee Tuberculosis Program is waived. Conditions of Wavier: - Follow the U. S. Centers for Disease Control and Prevention 's "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for	21410			

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21410	Continued From page 37 infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms. - Assign administrative responsibility for the TB infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below. - Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures are not taken. - Perform an investigation in collaboration with the local health department if health-care-associated transmission of M. tuberculosis is suspected. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to designate appropriate personnel the administrative responsibilities of the Infection	21410			

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21410	Continued From page 38 Control Program, and conduct an annual facility tuberculosis (TB) risk assessment. Findings include: During interview on 1/31/13, at 2:00 p.m., the director of nursing and infection control nurse verified there was no policy for an Infection Control Plan including designation of staff who are qualified to oversee the plan. The infection control nurse was not able to provide a TB risk assessment, and verified she was not aware that an assessment should be conducted annually. She stated the facility is in a low risk area for TB. The Tuberculosis Exposure Control Plan policy dated 8/11, documented: ... a risk assessment will be conducted annually using information provided by the Minnesota Department of Health and the history of TB of the nursing home. Suggested Method for Correction: The administrator or designee could designate appropriate personnel to oversee the infection control program. The person designated could ensure the facility has a system in place to ensure the facility policies follow CDC (Centers for Disease Control) guidelines. Revise the system as needed and educate staff on the system in place. Conduct annual facility TB risk assessments. The quality assurance committee could monitor for compliance. Time Period for Correction: Fourteen (14) days	21410			
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program	21415			

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21415	Continued From page 39 Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.	21415			

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21415	Continued From page 40 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a two-step tuberculin skin test (TST) were administered accurately for 1 of 5 employees whose files were reviewed for TB screening. Findings include: Staff-A was hired on 9/24/12. Staff A was hired from another health care facility who administered the 2 step TST. The 1st step was given on 9/17/12, and the result was read as (-) "negative" on 9/19/12. The 2nd step was given on 10/22/12 (33 days later), and the results was read as (-) "negative. During interview the payroll clerk stated staff-A's 2 step was not given accurately and according to the facilities policy. The document titled "Tuberculosis Exposure Control Program for Employee Protocol" dated 8/11, provided by the payroll clerk was reviewed. The policy indicated a mantoux was given upon hire and a 2nd mantoux needed to be given within three weeks of the 1st mantoux.	21415			

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21415	Continued From page 41 On 2/1/3, at 1:30 p.m. the DON stated the facility should not have accepted Staff-A's 2 step TST that had been completed while working at another facility. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure TB policies and procedures were developed and implemented to ensure completion of the two step mantoux for all newly hired employees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21415			
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow currently accepted principles for the disposal of controlled substances for 5 of 5 residents (R28, R62, R22, R42, and R41) who were prescribed Fentanyl patches. Findings include: During the medication storage review conducted	21610			

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21610	Continued From page 42 on 1/31/13, at 2:45 p.m. licensed practical nurses (LPN)-A and LPN-B both verified used Fentanyl patches prescribed to residents were routinely disposed of by folding the patch and placing them into the sharps containers on the medication cart. The full sharps containers were then placed in a utility/equipment room until picked up by the waste vendor. LPN-B reported there were five residents in the facility that were currently prescribed Fentanyl patches: R28, R62, R22, R42 and R41. LPN-A also verified the pharmacy consultant had informed the facility the patches should be disposed of by cutting, flushing and/or witnessed destruction. However, the facility had not initiated that procedure largely because of the difficulty in getting another licensed staff to witness the process. LPN-B also reported the nurses dated the patches when applied, but they were routinely not checked again until the time they were to be changed. On 2/1/13, at 8:45 a.m. the director of nursing (DON) verified the facility had no policies developed to address disposition of Fentanyl patches and other controlled medications. The DON also verified the pharmacy consultant had previously recommended the facility develop and adopt the policy of witnessed destruction of the Fentanyl patches, but indicated they had not been doing that. In addition, storage methods for these controlled medications awaiting final disposition had not been addressed. Suggested Method of Correction: The facility could develop a policy and procedure on the destruction of narcotic medication patches and	21610			

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21610	Continued From page 43 educate the staff. The DON or designee could conduct random audits and report to the quality assurance committee. Time period for correction: Ten (10)days	21610			
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain one or both sides of anti-rollback wheelchair brake devices according to manufacturer's recommendations for functional operation for 3 of 6 residents (R47, R71, R59) that utilized these devices on their wheelchairs. Findings include: R47 was reviewed for a fall on 1/9/13, that involved falling in the bathroom between the wheelchair and the sink. R47 was noted to have a brake device (SafeTMate) on her wheelchair; however, the device was not identified in the care plan or the post-fall review competed in the interdisciplinary notes the day of the fall. On 1/30/13 at 2:15 p.m., the director of nursing (DON) reported during interview R47 was actually	21685			

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21685	Continued From page 44 not assessed for use of the SafeTMate brake and the nursing staff was not sure why she used a wheelchair with the device. The DON also verified the facility purchased a number of the devices last year following being introduced to them at a provider meeting. She added no training was provided to the nursing staff on proper use, application or functional operation checks. The DON said the devices could be used with residents who were at risk of falls and did not remember to manually lock the brakes on the chair themselves. On 1/31/13 at 1:30 p.m. the SafeTMate device used by R47 was checked for proper operation with maintenance staff-A and found to not be operating properly on both rear wheels and would not prevent the wheelchair from rolling away and lock the wheels when the resident was not in the chair. The device on two other wheelchairs used by R71 and R59 were also observed to lock only one rear wheel and the chair would rotate away from the resident if needed. Maintenance staff (MS)-A verified the three chairs were out of adjustment and needed to be repaired to work properly. MS-A also verified he applied the devices to wheelchairs, but the devices did not receive regular routine preventative maintenance checks for function and remained on the wheelchairs when they were stored and were used among different residents. MS-A also reported the only time he adjusted the wheelchair devices was when nursing staff reported they were not operating correctly. The manufacturer's instruction manual for the SafeTMate brake devices identified the anti-rollback device should be inspected periodically to ensure that all the mounting hardware was securely tightened and the brake	21685			

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21685	Continued From page 45 arms were in proper adjustment. The instructions noted if the device was properly adjusted, it functioned as a back-up system that may reduce injuries when the factory brakes were not applied. SUGGESTED METHOD OF CORRECTION: The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable, sanitary and homelike manner. Ongoing maintenance, monitoring and record keeping to ensure that the environment, including resident rooms and equipment are maintained. They could develop a system to audit the environment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21685			
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980			

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21980	Continued From page 46 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a thorough investigation	21980			

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21980	Continued From page 47 was completed for 3 of 6 residents (R3, R56, R85) reviewed with issues involving potential mistreatment, neglect, abuse, and injuries of unknown origin; and failed to report immediately misappropriation of property for 1 of 1 resident (R59). Findings include: R3's gastrostomy feeding tube was pulled out by another resident without timely report to the State agency and lacked thorough investigation. The incident report dated 10/7/12, at 6:45 p.m. indicated a confused resident entered R3's room and pulled out his feeding tube with balloon inflated. The report to Office Health Facility Complaint (OHFC) dated 10/8/12, indicated the report was being filed for "physical abuse." The report was brief and documented a resident who lived across the hall from R3 entered his room and pulled out his feeding tube. Staff entered the room and found the feeding tube in his hand with the balloon still inflated. The DON stated there was no investigation as she believed the resident intended no harm. R3's feeding tube was replaced and resident moved to another location. R56 fell and sustained an injury of unknown origin (fractured hip) without thorough investigation to rule out potential neglect of care. The incident report dated 1/24/12, at 6:20 a.m. indicated a licensed practical nurse (LPN) heard alarm sound and found the resident in his room on the bathroom floor on left side. R56 complained of hip pain when transferred. The OHFC report, dated 1/24/12, indicated the report was being filed for "injuries of unknown source." The LPN was in report and heard alarm sounding. When she got to the door she heard a loud bang and resident hollered out. Lying on his left side in bathroom with his legs out of his	21980			

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21980	Continued From page 48 bathroom and head towards the opposite door. No staff present in the room. Resident had been up 8 times during the night to go to bathroom. Complaints of hip pain and was sent to emergency room. R56 was diagnosed with fractured hip. The director of nursing (DON) stated on 1/31/13, at 2:00 p.m. that she had conducted the investigation. She verified the investigation did not include any interviews with nursing assistants or any other staff involved to determine if the plan of care was being followed at the time of the incident. DON stated she does not have separate files where she has additional investigation information other than what is sent to OHFC. R85 sustained an injury of unknown origin without thorough investigation to determine if abuse/neglect occurred. The incident report dated 12/6/12, indicated that during the night shift at 2:34 a.m. staff noted a 5 x 7 centimeter (cm) raised purple bruised area on right wrist and a 2 x 1 and 3 x 1 cm maroon colored bruise on left forearm. The OHFC Report indicated staff reported while transferring resident with the PAL (mechanical standing) lift on 12/5/12, the resident put her hands on the inside of the PAL sling several times while transferring. Bruising on wrist and forearm is consistent with PAL sling placement. There is no alleged perpetrator and information is from credible source. Care plan updated to ensure proper hand placement. The DON stated she conducted the investigation and interviewed staff. She verified she does not document any interviews with staff during her investigations. The only investigative report is what is submitted to OHFC. The Greenwood Connections Neglect/Abuse	21980			

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21980	Continued From page 49 Policy, dated 12/28/11, documents: 1). Ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property are reported immediately to the administrator of the facility, MN Department of Health and Common Entry Point. 2). Have evidence that all alleged violations are thoroughly investigated, ... R59 reported missing \$100.00 in February of 2012 and it was not reported and not thoroughly investigated. R59 ' s quarterly Minimum Data Set (MDS), dated 01/10/2012, and quarterly MDS, dated 12/11/13, identified that R59 was moderately cognitively impaired. On 1/28/2013 at 7:00 p.m., R59 said she had one hundred dollars (\$100.00) taken from under her pillow. R59 said that she reported the missing money but they (the facility) didn ' t look very hard for it. R59 ' s Green Pine Acres Resident Trust Request Form, dated 2/10/12, identified that R59 requested " \$100.00 check be made out to ' R59 ' out of my resident account at Green Pine Acres Nursing Home. " The request form ' s signature line was signed by R59. A note text in R59 ' s progress note by social services, dated 2/10/2012 at 15:08 (3:08 p.m.), indicated that " Writer delivered a purchase made on behalf of Res. And cash requested (from her resident account) to her. Res ' earlier request for transportation to shop for clothing was referred to the Activities director to address, next week (Res. Is aware of this). " A Resident Missing Items Procedure facility form, dated and timed 2/18/2012 at 1000 (10:00 am), identified that R59 was missing \$100.00. This missing items form identified that " If the items(s) is/are not located within twenty-four	21980			

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21980	Continued From page 50 (24) hours: step " 9) RN notify the director of nursing and/or Administrator. " Although this step had an initial, there was no indication when the director of nursing and/or the administrator where notified. A health status progress note, dated 2/21/2012 at 10:55 " Late Entry: Note Text: Did talk with resident regarding missing money. Did search her room with another RN and no money was found. At first, she stated it was gone on the 17th and later she said was gone on the 10th. " The missing items report indicated on 2/21/12 that R59 reported the money missing on the 18th. The investigation was dated 2/21/12 and signed by the DON. The DON interviewed R59, the receptionist, and two nursing assistants working on 2/17/12. There was no other investigation information available. When interviewed, on 2/1/2013 at 1:12 p.m. the social worker (SW) said that he wasn ' t involved in the process of missing items unless it was brought to his attention and that the director of nursing does the final investigation, then takes it to the administrator and they determine if there is anything to be done. During interview, on 2/1/2013 at 2:03 p.m., the administrator said that he did not remember when he was notified of the missing money. He was unable to provide additional information. On 02/1/2013, at 2:42 p.m., the DON said that she did not recall interviewing other individuals on other shifts. In addition, she said that the missing \$100.00 should have been reported and that she couldn ' t find where this had been done. A review of the facility ' s undated policy, entitled, Resident Missing Items Procedure, directed staff to " 1). Establish item missing. 2). Report the	21980			

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21980	Continued From page 51 missing item to the team leader. 3) Team leader give note to head of housekeeping and laundry staff. 4). Team leader to notify RN. 5). Team leader call family or legal guardian of item missing 6). Team leader to document in nursing notes, item missing and notification to family or legal guardian. 7). RN to notify Director of Nursing and / or Administrator. 8). D.O.N. To conduct an internal investigation of foul play suspected. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported timely and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980			
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse,	22000			

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22000	Continued From page 52 and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000			

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22000	Continued From page 53 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy and procedures related to possible abuse and neglect to ensure a thorough investigation was completed for 3 of 6 residents (R3, R56, R85) reviewed with issues involving potential mistreatment, neglect, abuse, and injuries of unknown origin; and failed to report immediately misappropriation of property for 1 of 1 resident (R59). Findings include: R3's gastrostomy feeding tube was pulled out by another resident without timely report to the State agency and lacked thorough investigation. The incident report dated 10/7/12, at 6:45 p.m. indicated a confused resident entered R3's room and pulled out his feeding tube with balloon inflated. The report to Office Health Facility Complaint (OHFC) dated 10/8/12, indicated the report was being filed for "physical abuse." The report was brief and documented a resident who lived across the hall from R3 entered his room and pulled out his feeding tube. Staff entered the room and found the feeding tube in his hand with the balloon still inflated. The DON stated there was no investigation as she believed the resident intended no harm. R3's feeding tube was replaced and resident moved to another location. R56 fell and sustained an injury of unknown origin (fractured hip) without thorough investigation to rule out potential neglect of care. The incident report dated 1/24/12, at 6:20 a.m. indicated a licensed practical nurse (LPN) heard alarm sound and found the resident in his room on the bathroom floor on left side. R56 complained of hip pain when transferred. The	22000			

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NAME OF PROVIDER OR SUPPLIER GREEN PINE ACRES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 427 MAIN STREET NORTHEAST MENAHA, MN 56464		
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22000	Continued From page 54 OHFC report, dated 1/24/12, indicated the report was being filed for "injuries of unknown source." The LPN was in report and heard alarm sounding. When she got to the door she heard a loud bang and resident hollered out. Lying on his left side in bathroom with his legs out of his bathroom and head towards the opposite door. No staff present in the room. Resident had been up 8 times during the night to go to bathroom. Complaints of hip pain and was sent to emergency room. R56 was diagnosed with fractured hip. The director of nursing (DON) stated on 1/31/13, at 2:00 p.m. that she had conducted the investigation. She verified the investigation did not include any interviews with nursing assistants or any other staff involved to determine if the plan of care was being followed at the time of the incident. DON stated she does not have separate files where she has additional investigation information other than what is sent to OHFC. R85 sustained an injury of unknown origin without thorough investigation to determine if abuse/neglect occurred. The incident report dated 12/6/12, indicated that during the night shift at 2:34 a.m. staff noted a 5 x 7 centimeter (cm) raised purple bruised area on right wrist and a 2 x 1 and 3 x 1 cm maroon colored bruise on left forearm. The OHFC Report indicated staff reported while transferring resident with the PAL (mechanical standing) lift on 12/5/12, the resident put her hands on the inside of the PAL sling several times while transferring. Bruising on wrist and forearm is consistent with PAL sling placement. There is no alleged perpetrator and information is from credible source. Care plan updated to ensure proper hand placement. The DON stated she conducted the investigation	22000			

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22000	Continued From page 55 and interviewed staff. She verified she does not document any interviews with staff during her investigations. The only investigative report is what is submitted to OHFC. The Greenwood Connections Neglect/Abuse Policy, dated 12/28/11, documents: 1). Ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property are reported immediately to the administrator of the facility, MN Department of Health and Common Entry Point. 2). Have evidence that all alleged violations are thoroughly investigated, ... R59 reported missing \$100.00 in February of 2012 and it was not reported and not thoroughly investigated. R59 ' s quarterly Minimum Data Set (MDS), dated 01/10/2012, and quarterly MDS, dated 12/11/13, identified that R59 was moderately cognitively impaired. On 1/28/2013 at 7:00 p.m., R59 said she had one hundred dollars (\$100.00) taken from under her pillow. R59 said that she reported the missing money but they (the facility) didn ' t look very hard for it. R59 ' s Green Pine Acres Resident Trust Request Form, dated 2/10/12, identified that R59 requested " \$100.00 check be made out to ' R59 ' out of my resident account at Green Pine Acres Nursing Home. " The request form ' s signature line was signed by R59. A note text in R59 ' s progress note by social services, dated 2/10/2012 at 15:08 (3:08 p.m.), indicated that " Writer delivered a purchase made on behalf of Res. And cash requested (from her resident account) to her. Res ' earlier request for transportation to shop for clothing was referred to the Activities	22000			

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22000	Continued From page 56 director to address, next week (Res. Is aware of this). " A Resident Missing Items Procedure facility form, dated and timed 2/18/2012 at 1000 (10:00 am), identified that R59 was missing \$100.00. This missing items form identified that " If the items(s) is/are not located within twenty-four (24) hours: step " 9) RN notify the director of nursing and/or Administrator. " Although this step had an initial, there was no indication when the director of nursing and/or the administrator where notified. A health status progress note, dated 2/21/2012 at 10:55 " Late Entry: Note Text: Did talk with resident regarding missing money. Did search her room with another RN and no money was found. At first, she stated it was gone on the 17th and later she said was gone on the 10th. " The missing items report indicated on 2/21/12 that R59 reported the money missing on the 18th. The investigation was dated 2/21/12 and signed by the DON. The DON interviewed R59, the receptionist, and two nursing assistants working on 2/17/12. There was no other investigation information available. When interviewed, on 2/1/2013 at 1:12 p.m. the social worker (SW) said that he wasn' t involved in the process of missing items unless it was brought to his attention and that the director of nursing does the final investigation, then takes it to the administrator and they determine if there is anything to be done. During interview, on 2/1/2013 at 2:03 p.m., the administrator said that he did not remember when he was notified of the missing money. He was unable to provide additional information. On 02/1/2013, at 2:42 p.m., the DON said that she did not recall interviewing other individuals on other shifts. In addition, she said that the missing	22000			

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22000	Continued From page 57 \$100.00 should have been reported and that she couldn ' t find where this had been done. A review of the facility ' s undated policy, entitled, Resident Missing Items Procedure, directed staff to " 1). Establish item missing. 2). Report the missing item to the team leader. 3) Team leader give note to head of housekeeping and laundry staff. 4). Team leader to notify RN. 5). Team leader call family or legal guardian of item missing 6). Team leader to document in nursing notes, item missing and notification to family or legal guardian. 7). RN to notify Director of Nursing and / or Administrator. 8). D.O.N. To conduct an internal investigation of foul play suspected. SUGGESTED METHOD FOR CORRECTION: The Director of Nurses and the Social Worker could provide additional education to all staff regarding reporting responsibilities and immediate investigation to ensure implementation of the procedures of the facility's Abuse Prevention Policy. The quality assurance program could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	22000			