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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2GXG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00588

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245125**

2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/22/2014**

6. DATE OF SURVEY **01/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
02/28

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

12.Total Facility Beds **24** (L18)

13.Total Certified Beds **24** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christine Campbell, Unit Supervisor 02/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/15/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245125

February 13, 2015

Ms. Jessica Raad, Administrator
Fitzgerald Nursing And Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

Dear Ms. Raad:

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

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

Effective January 9, 2015 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 26, 2015

Ms. Jessica Raad, Administrator
Fitzgerald Nursing And Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125027

Dear Ms. Raad:

On December 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 11, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On January 26, 2015, 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 December 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 11, 2014, effective January 9, 2015 and therefore remedies outlined in our letter to you dated December 22, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

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

5125r15

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245125	A. Building B. Wing	1/26/2015

Name of Facility	Street Address, City, State, Zip Code
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **01/09/2015**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **01/09/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/09/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/26/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	02/262015	13922	01/26/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/11/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GXG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00588

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(L1) **245125**
2.STATE VENDOR OR MEDICAID NO.
(L2) **112847700**

3. NAME AND ADDRESS OF FACILITY
(L3) **FITZGERALD NH AND REHAB**
(L4) **227 MCKINLEY AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/22/2014**

6. DATE OF SURVEY **12/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
02/28

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NE II 12/31/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/15/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :
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05/15/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 22, 2014

Ms. Jessica Raad, Administrator
Fitzgerald Nursing Home And Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

RE: Project Number S5125027

Dear Ms. Raad:

On December 11, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Christine Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Christine.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 11, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 11, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Census: 22 During the survey started on 12/8/14, an extended survey was initiated on 12/9/14 through 12/11/14.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act on resident complaints, for 1 of 1 resident (R13) who expressed complaints of his roommate's behavior and requested a new room assignment.	F 166	F166 A. It is the Facility practice to acknowledge and act on resident/family concerns. B. The facility's grievance/concern policy	1/9/15

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

Electronically Signed | 12/31/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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F 166	Continued From page 1 Findings include: R13, interviewed on 12/8/14, at 4:48 p.m., stated, "The administration could stand to watch [his roommate] sometimes and see how he treats others." R13 stated the roommate appeared somewhat threatening and added, "Let me put it this way, I don't trust him..." R13 stated some of the nursing assistants (NAs) were aware of how he felt, but he had not reported it to licensed staff or administration. R13's admission Minimum Data Set (MDS) dated 11/17/14, identified moderate cognitive impairment. R13's Resident Progress Note authored by licensed practical nurse (LPN)-F dated 12/5/14, at 6:36 p.m. noted, "Wants to switch rooms due to another res [resident's] behaviors, [R13] did not want to go in his room after supper due to other res [resident's] behaviors, he went [and] sat in TV rm [television room] instead." No follow-up was completed for R13's request for a room change. During interview on 12/11/14, at 10:34 a.m. social service director (SSD) confirmed she handled all resident room change requests. SSD denied knowledge of R13's request to change rooms. Upon review of R13's 12/5/14, progress note SSD confirmed LPN-F should have forwarded the request to her for follow-up. The director of nurses (DON) was interviewed on 12/11/14, at 2:28 p.m. and stated the facility's process to address resident complaints was to report "up the chain of command." She confirmed that a resident's request for room change as well	F 166	has been revised and reviewed for appropriateness. C. All staff members will be educated about revision of the policy and the proper chain of communication regarding registering a resident/family member concern. All concerns will be given to the Administrator. D. Resident R13 was offered a room change and has since moved rooms. E. Follow-up audits of resident/family concerns will be completed daily for two weeks, then weekly for one month by the Director of Social Services. The need for ongoing monitoring of resident/family concerns will be determined by the Quality Assurance Committee. F. Correction Date: 01/09/2015	

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F 166	Continued From page 2 as complaints of another resident's behavior should be addressed. The DON confirmed she was not informed of R13's concern about the room mate or request for a room change. The facility's undated Complaint/Concern Policy noted residents and/or their legal representative were encouraged to exercise their rights by presenting complaints or concerns on behalf of themselves or others in effort to improve resident care.	F 166		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility social service staff did not refer or provide consultative services to address behavioral concerns for 1 of 1 resident (R15) reviewed for verbal/physical aggression. Findings include: R15's nurse Practioner (NP)-A note dated 9/10/14, identified diagnoses including depression, aphasia and history of a large, left-middle cerebral artery Cerebrovascular accident (CVA/ stroke) in 9/13. The quarterly Minimum Data Set (MDS) dated	F 250	F250 A. It is Facility practice to seek outside behavioral consulting services for residents displaying behavioral concerns. B. Referral for resident R15 has been made for outside consulting services. C. Resident R15 has an updated aggressive behavior monitoring program in place. D. Facility wide audit for all residents completed to review behavioral needs and if appropriate behavioral monitoring interventions implemented. E. The Director of Social Services will review behavioral notes and concerns	1/9/15

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F 250	Continued From page 3 10/8/14, identified R15 with severely impaired cognition, inattention and disorganized thinking. The MDS identified R15 with verbal behavioral symptoms including threatening, screaming or cursing directed toward others. The Care Area Assessment (CAA) dated 1/7/14, noted R15 became angry/frustrated and yelled or hollered due to inability to express himself clearly. R15's care plan revised 11/7/14, directed the following behavioral interventions: Use of a positive approach during cares, explaining and showing R15 what was needed; Use of positive reinforcement of good behaviors through verbal praise; Documenting triggers, such as the environment, staff approach, exiting of visitors, or doing cares, and; Use of redirection to diffuse anger in a positive way. The care plan also noted, "[R15] has difficulty communicating and making self understood d/t [due to] impaired cognition. Speech is garbled most of the time, which can lead to social isolation." Interventions included visits by volunteers, informing him of upcoming activities, involving him with others who had shared interests, providing one-to-one sessions and providing him with materials of interest. Additional interventions for R15 included allowing extra time for self-expression and periodic approaches to ensure routine needs were met. R15's progress notes dated 9/11/14, through 12/11/14, revealed repeated incidents of aggressive behavior with ineffective intervention attempts. R15's aggressive behaviors included cursing, running wheelchair into others, screaming, shaking his closed fist at staff, verbal threats to kill others, hitting/kicking walls/wall hangings and physically assaulting staff.	F 250	within 24-72 hours. F. The Director of Social Services or designee will audit weekly to ensure that the proper follow-up regarding behavioral concerns and use of behavioral consulting services as necessary. Administrator will audit for proper follow-up regarding behavioral concerns and the use of behavioral consulting services as necessary. G. Correction Date: 01/09/2015	

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F 250	Continued From page 4 R15's Point of Care History on 10/5/14, identified physical abuse directed toward others, verbal abuse directed toward others and rejection of care. The behaviors placed R15 at significant risk for physical injury, significantly interfered with resident care, significantly interfered with his participation in activities or social interactions, placed others at significant risk for injury, intruded on the privacy or activity of others and significantly disrupted care or living environment. On 12/6/14, behavioral notes described wandering and verbal abuse toward others. R15's abusive behaviors toward others were noted to significantly disrupt care of living environment within the facility. During intermittent observations throughout the survey period on 12/8/14, from 1:00 p.m. to 8:00 p.m., on 12/9/14, from 8:00 a.m. to 5:30 p.m., on 12/10/14, from 7:00 a.m. to 3:30 p.m. and on 12/11/14, from 8:00 a.m. to 5:00 p.m., R15 wandered up and down the hallway, self-propelling in his wheelchair. Anytime a surveyor walked by, he called out and reached his hand out. When greeted kindly, R15 continued to speak unintelligibly and pulled the hand of the person toward him. R15 was not observed to be physically aggressive or threatening but called out loudly and attempted to follow people off the unit. R15 was noted as a tall, younger male (approximately sixty years old), with broad shoulders and a strong appearance. During observation of the evening meal on 12/8/14, at 5:40 p.m. R15 self propelled the wheelchair into the dining room. R15 was unable to make his way to his place setting at the far side of one of the dining room tables because of limited space between the table and R28 who	F 250		

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was seated at the neighboring table. R15 persisted with self-propelling through the narrow space, repeatedly pushing into the resident's wheelchair. Several staff in the area and told R15 to be patient and wait for the staff to move the table to make room to pass. R15 was visibly upset, yelled out and abruptly shoved the table and a chair.

The administrator, interviewed about staff training on 12/9/14, at 3:57 p.m., stated a plan was being developed on how to proceed, staff were trained to manage R15's behavior, the pharmacist was involved in recommending medication adjustments, and NP-A was also involved.

During interview on 12/10/14, at 12:20 p.m. nursing assistant (NA)-H reported the facility had instructed staff to tell other residents to just ignore/avoid R15 and let staff deal with him.

During interview on 12/11/14, at 8:35 a.m. activities director (AD) reported there were few activities where R15 remained for any real length of time. She stated, "He has a very short interest span." AD reported she did not have any structured or formal one-to-one activity times with R15, but did try to do one-to-ones with him when he looked bored or appeared to be in need of a distraction. AD reported R15's behavior triggers included staff being too busy to stop and give him the attention that he wanted.

During interview on 12/11/14, at 10:34 a.m. social service director (SSD) denied knowledge of R15 physically or verbally aggressing toward other residents. She added, "We try to calm him down, see if he needs anything ... We just try to talk him down, sometimes it is successful, sometimes it

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F 250	Continued From page 6 just isn't." SSD was unable to offer an estimate of the level of success with implementation of current redirection techniques for R15's behaviors. She stated, "He does not seem to understand inability for immediate gratification of what he wants ... Trying to communicate his needs is a trigger." SSD reported she had only been in the social service role for approximately one and one-half months. During interview on 12/11/14, at 2:28 p.m. the director of nursing (DON) stated there had been no referral to outside resources. The NP was adjusting medications for R15 but did not make a referral to geriatric psychiatry or other resources. During interview on 12/11/14, at 2:44 p.m. administrator identified attempted behavioral interventions included referral to a specialized care home, seeking help with behavioral interventions from the specialized care provider. The IDT also conducted some research on the cognitive and behavioral effects of a stroke. The administrator reported the IDT contacted a family member who was able to share some of R15's social history to provide a baseline. R15's spouse was also able to share his likes and preferences, helping facility staff to be more proactive, instead of reactive. In addition, the administrator reached out to the consultant pharmacist and nurse practitioner to consider medication management options for assistance in management of R15's behaviors. The facility's undated, Dealing with Residents who have Aggressive, Demanding and/or Difficult Behavior policy instructed all residents were to be protected and staff were to be educated on dealing with difficult, demanding and aggressive	F 250		

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F 250	Continued From page 7 behavior.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for monitoring potential side effects, efficacy and/or target behaviors of medications for 2 of 6 residents (R2, R32) reviewed for unnecessary medications. Findings include: The quarterly Minimum Data Set (MDS) dated	F 279	F 279 A. It is Facility practice to develop a plan of care to include resident monitoring for side effects, efficacy, and/or target behaviors. B. Facility wide audit completed to ensure that the resident plan of care includes resident monitoring for side effects, efficacy, and/or target behaviors as needed.	1/9/15

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F 279	Continued From page 8 10/21/14, identified R2 had moderate cognitive impairment. The MDS indicated R2 had no symptoms of delirium or depression; had no behaviors; had diagnoses of dementia, depression and Cerebrovascular accident (CVA); and received antipsychotic, antidepressant and anticoagulant medication seven out of seven days during the assessment period. The signed Physician Orders dated 11/26/14, included paroxetine (Paxil) 20 milligrams (mg) once daily for depression (order started 5/1/12); Zyprexa (antipsychotic) 5 mg at bedtime for dementia with delusions (order started 5/1/12); and warfarin (anticoagulant) 3 mg every day for a diagnosis of CVA (order started 10/30/14). R2 was periodically observed from 12/9/14 through 12/11/14, with no evidence of bruising, bleeding, behaviors or possible psychotropic medication side effects noted. The Psychotropic Drug Use care plan edited 10/18/14, indicated R2 received Zyprexa for depression, had a history of suicidal attempts and a goal of not harming himself. The care plan directed staff to monitor R2 for behaviors that were not customary such as; a loss of interest to read, attend activities and or attend social events; and verbal or physical aggression. In addition the care plan indicated R2 had failed past attempts of gradual dose reductions for the Zyprexa. The care plan did not identify monitoring for potential risks, side effects or effectiveness of Zyprexa, Paxil or anticoagulant medications. On 12/11/14, at 9:45 a.m. the director of nursing (DON) verified that warfarin and the	F 279	C. Resident R2□s plan of care has been revised and updated to include interventions for monitoring for potential risks and side effects from Zyprexa, Paxil, and anti-coagulant use in the Medication Administration Record. Resident R32□s plan of care has been revised and updated to include interventions for monitoring for potential risks and side effects from hypnotic, antianxiety, and antidepressant medication use in the Medication Administration Record. D. The plan of care for all current residents have been reviewed for appropriate interventions and revisions that include monitoring for side effects, efficacy, and/or target behaviors and added if necessary. E. All Licensed Nursing Staff have been educated on December 29, 2014 on updating/revision of the resident plan of care should a psychotropic medication be prescribed for a resident within the facility. F. The Director of Nursing or designee will audit weekly for the proper care planning of psychotropic drug use and audit findings will be reported to Quality Assurance for ongoing monitoring. G. Correction Date: 01/09/2015	

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antidepressant were not addressed on the care plan. The DON stated there was no evidence of monitoring potential side effects of anticoagulant medication.

R32's care plan did not address assessed needs, interventions or approaches related to hypnotic, antidepressant and anti-anxiety medications.

R32 was admitted on 10/19/14. The admission Minimum Data Set (MDS) dated 10/28/14, indicated R32 was cognitively intact and had diagnoses including hypertension, anxiety disorder and depression.

The psychotropic drug care area assessment (CAA) dated 10/28/14 indicated R32's was unable to sleep at night and was taking antianxiety, antidepressant, and sedative/hypnotic medications.

R32's physician medication orders current in the electronic health record indicated Ambien (hypnotic medication) 5 milligrams (mg) by mouth for insomnia at bedtime; Celexa (antidepressant) 20 mg by mouth at bedtime; and Ativan (antianxiety medication) 0.5mg by mouth for anxiety once a day.

The DON, interviewed on 12/11/14, stated verified R32 was taking all three medications and the interventions and monitoring for insomnia, depression and anxiety should be on the care plan but were not.

The facility's Comprehensive Care Plans policy dated 5/8/13, identified comprehensive care plans were developed and revised based on resident assessment and included services that were to

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F 279	Continued From page 10 be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, identify, implement and monitor effective behavioral interventions for 1 of 1 resident (R15) who demonstrated verbally and physically aggressive behaviors directed toward others. Findings include: R15's nurse Practioner (NP)-A note dated 9/10/14, identified diagnoses including depression, aphasia and history of a large, left-middle cerebral artery Cerebrovascular accident (CVA/ stroke) in 9/13. The progress note indicated, R15's "Depression... appears to be controlled at this point and he has not had any recent aggressive behaviors towards staff or other residents... He is currently on citalopram [Celexa, an antidepressant medication] and this appears to be working well for him."	F 309	F309 A. It is facility practice to complete a comprehensive assessment for all residents. All residents will have a review of necessary behavioral interventions and effectiveness included in the assessment. Facility□s procedure for comprehensive assessments have reviewed and revised. B. Upon return to the facility, resident R15 will have a comprehensive assessment completed and care plan will be reviewed and revised. C. All staff responsible for completing comprehensive resident assessments have been educated to the procedure and the requirements for a complete comprehensive assessment, including ongoing monitoring and effectiveness. D. The Director of Social Services will audit weekly for ongoing monitoring and effectiveness of resident care planned	1/9/15

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F 309	Continued From page 11 The quarterly Minimum Data Set (MDS) dated 10/8/14, identified R15 had unclear speech and sometimes understood simple, direct communication from others. R15 had severely impaired cognition, with inattention and disorganized thinking. The MDS identified R15 with verbal behavioral symptoms directed toward others, including threatening, screaming or cursing at others. No physical behavioral symptoms were identified. R15 was noted as independent with locomotion on the unit and required limited assistance for transfers and ambulation. The Care Area Assessment (CAA) dated 1/7/14, noted R15 became angry/frustrated and yelled or hollered out for staff or at staff due to inability to express himself clearly. The CAA noted, "Resident has not attempted to physically harm self or others. Out of frustration, due to inability to verbalize needs, has physically refused cares by staff due to mis-communication. No potential for harm to self or others." The medical record lacked evidence of a comprehensive evaluation of behavioral patterns, antecedents/historical triggers, baseline frequency, baseline intensity and interventions attempted but failed. R15's care plan revised 11/7/14, R15's care plan revised 11/7/14, noted, "[R15] shows negative aggression towards staff and residents. Triggering factors such as environment, staff member approach, exiting of visitors... [R15] will be able to decrease the number of negative physical behaviors by 1 [one] a week... [R15] will be able to avoid a physical aggressive response towards staff and residents." Interventions included the following: Use of a positive	F 309	behavioral interventions. E. Audit findings will be reported to the Quality Assurance Committee for ongoing auditing. F. Correction Date: 01/09/2015	

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approach during cares, explaining and showing R15 what was needed; Use of positive reinforcement of good behaviors through verbal praise; Documenting triggers, such as the environment, staff approach, exiting of visitors, or doing cares, and; Use of redirection to diffuse anger in a positive way. The care plan also noted, "[R15] has difficulty communicating and making self understood d/t [due to] impaired cognition. Speech is garbled most of the time, which can lead to social isolation." Interventions included visits by volunteers, informing him of upcoming activities, involving him with others who had shared interests, providing one-to-one sessions and providing him with (unidentified) materials of interest. Additional interventions for R15 included allowing extra time for self-expression and periodic approaches to ensure routine needs were met.

R15's progress notes dated 9/11/14, through 12/11/14, revealed repeated incidents of aggressive behavior with ineffective intervention attempts. R15's aggressive behaviors included cursing, running wheelchair into others, screaming, shaking his closed fist at staff, verbal threats to kill others, hitting/kicking walls/wall hangings and physically assaulting staff. The medical record lacked evidence of systematic behavior monitoring to determine antecedents, specific behaviors or effectiveness of attempted interventions.

Nursing notes on 10/25/14, at 2:37 p.m. indicated R15 became very angry when other [unidentified] resident told them to please stay out of their stuff. R15 took bag of candy from other resident's dresser drawer. Staff were called into the room by call light and R15 became verbally aggressive

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F 309	Continued From page 13 with resident and staff. Nursing notes on 11/21/14, at 3:29 p.m. indicated R15 was swearing in hallway and didn't want to let [two residents] out of their bedroom. All behavior monitoring for R15 during the period of 9/11/14, through 12/11/14, was requested for review. The following documentation was provided in addition to the progress notes above: · On 10/5/14, R15's behavior documentation described verbal and physical abuse directed toward others and rejection of care. The behaviors placed R15 at significant risk for physical injury; significantly interfered with resident care and participation in activities or social interactions; placed others at significant risk for injury; intruded on the privacy or activity of others; and significantly disrupted care or living environment. Behavior interventions attempted included redirection, offering of food/fluids, one-to-one time with staff and returning R15 to his room. R15's behaviors were noted as easily altered with implementation of these interventions. On 12/6/14, the behavioral documentation noted R15 wandered and was verbally abusive which significantly interfered with care and participation in social activities and disrupted the living environment within the facility. · Daily Stand Up/Medicare Meeting notes from 12/8/14, through 12/11/14, indicated behavior concerns for each resident were discussed on a daily basis. The notes lacked detail of behaviors or effectiveness of attempted interventions. There was no cumulative evaluation of antecedents, description of R15's behaviors or effectiveness of attempted interventions.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

(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 309	Continued From page 14	F 309		

During intermittent observations throughout the survey period on 12/8/14, from 1:00 p.m. to 8:00 p.m., on 12/9/14, from 8:00 a.m. to 5:30 p.m., on 12/10/14, from 7:00 a.m. to 3:30 p.m. and on 12/11/14, from 8:00 a.m. to 5:00 p.m., R15 wandered up and down the hallway, self-propelling in his wheelchair. R15 was not observed to be physically aggressive or threatening but called out loudly. R15 was noted as a tall male with broad shoulders and a strong appearance.

During observation of the evening meal on 12/8/14, at 5:40 p.m. R15 entered the dining room, self-propelling his wheelchair. R15 was unable to make his way to his place setting at the far side of one of the dining room tables because of limited space between the table and R28, who was seated in her wheelchair at the neighboring table. R15 persisted with self-propelling through the narrow space, repeatedly pushing into another resident's wheelchair with his own wheelchair. Several staff in the area, along with the residents at the neighboring table told him to hold on, be patient and wait for the staff to move the table so he would have enough room to maneuver to his place setting. R15 then became visibly upset, yelled out and abruptly shoved the table and a chair. His speech was unintelligible, with a loud volume and gruff tone.

During interview on 12/10/14, at 12:14 p.m. RN-A confirmed R15 did hit staff if they were trying to get him to do something he did not want to do. She reported staff reassured other residents by telling them it would not last long, not to engage with him and it would pass.

During interview on 12/10/14, at 12:20 p.m. NA-H

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	245125	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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F 309	Continued From page 15 said it was hard to say whether R15 would have targeted another resident when he got angry. NA-H reported the facility had instructed staff to tell other residents to just ignore/ avoid R15 and let the staff deal with him. During interview on 12/11/14, at 10:34 a.m. social service director (SSD) denied knowledge of R15 physically or verbally aggressing toward other residents. She indicated R15's interdisciplinary team was currently working on developing interventions to address R15's behaviors. SSD gave examples of current behavior interventions including the following: ensuring his needs were met (i.e. toileting), offering him coffee, informal one-to-one visits with herself and other administrative staff in the office area of the facility and encouraging activities of interest to him. She added, "We try to calm him down, see if he needs anything ... We just try to talk him down, sometimes it is successful, sometimes it just isn't." SSD was unable to offer an estimate of the level of success with implementation of current redirection techniques for R15's behaviors. She stated, "He does not seem to understand inability for immediate gratification of what he wants ... Trying to communicate his needs is a trigger." SSD reported she had only been in the social service role for approximately one and one-half month. During interview about facility interventions to address R15's behaviors on 12/11/14, at 2:44 p.m. the stated they consulted with another facility that typically provided services for individuals similar to R15, seeking ideas for how they educated their staff in recognizing and identifying behavior triggers and age appropriate responses to the behaviors. The IDT also conducted some	F 309		

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	245125	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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F 309	Continued From page 16 research on the cognitive and behavioral effects of a stroke. She added facility staff had received several training on these topics as a result of these resources. The administrator reported the IDT sought contact with a family member who was able to share some of R15's social history to provide a baseline. R15's spouse was also able to share his likes and preferences, helping facility staff to be more proactive, instead of reactive. In addition, the administrator reached out to the consultant pharmacist and nurse practitioner to consider medication management options for assistance in management of his behaviors. The administrator reported behavior management techniques were expected of staff in their support of R15, including, "When he is having behaviors, do not argue... let him be... remove others from the area... do not try to move him." She also reported the staff were to provide him with attention, letting him know they would be right back, avoiding certain terminology found to trigger inappropriate behavior, such as saying "goodbye." The facility's undated, Dealing with Residents who have Aggressive, Demanding and/or Difficult Behavior policy instructed all residents were to be protected from abuse and staff were to be educated on dealing with difficult, demanding and aggressive behavior.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	**227 MCKINLEY AVENUE EVELETH, MN 55734**

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K 000	INITIAL COMMENTS FIRE SAFETY SAFETY. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Fitzgerald Nursing Home & Rehab 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. Fitzgeral Nursing Home & Rehab is a 1-story building with a partial basement. The building was constructed in 1959, with one addition in 1996. The original building and the addition are Type I(111) therefore, the building was inspected as one building. The building also contains a mental health unit operated by others. The mental health portion of this building is not properly separated and was inspected on this date. The ESRD is properly 2 hour fire rated separated. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 24 beds and had a census of 22 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	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.

Electronically submitted
December 22, 2014

Ms. Jessica Raad, Administrator
Fitzgerald Nursing Home And Rehabilitation
227 McKinley Avenue
Eveleth, Minnesota 55734

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5125027

Dear Ms. Raad:

The above facility was surveyed on December 8, 2014 through December 11, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, 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.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Christine Campbell at (218) 302-6151 or email: christine.campbell@state.mn.us.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

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

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00588	A. BUILDING: _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FITZGERALD NH AND REHAB	227 MCKINLEY AVENUE EVELETH, MN 55734

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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 12/8/14, through 12/11/14, surveyors of this Department's staff, visited the above provider and the following correction orders are 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 Monitoring, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802 During the survey started on 12/8/14, an extended survey was initiated on 12/9/14 through 12/11/14. Census: 22	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for monitoring potential side effects, efficacy and/or target behaviors of medications for 2 of 6 residents (R2, R32) reviewed for unnecessary medications. Findings include: The quarterly Minimum Data Set (MDS) dated 10/21/14, identified R2 had moderate cognitive impairment. The MDS indicated R2 had no symptoms of delirium or depression; had no behaviors; had diagnoses of dementia,	2 560	A. It is Facility practice to develop a plan of care to include resident monitoring for side effects, efficacy, and/or target behaviors. B. Facility wide audit completed to ensure that the resident plan of care includes resident monitoring for side effects, efficacy, and/or target behaviors as needed. C. Resident R2□s plan of care has been revised and updated to include interventions for monitoring for potential risks and side effects from Zyprexa, Paxil, and anti-coagulant use in the Medication	1/9/15

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2 560	Continued From page 2 depression and cerebrovascular accident (CVA); and received antipsychotic, antidepressant and anticoagulant medication seven out of seven days during the assessment period. The signed Physician Orders dated 11/26/14, included paroxetine (commonly known as Paxil) 20 milligrams (mg) once daily for depression (order started 5/1/12); Zyprexa (antipsychotic) 5 mg at bedtime for dementia with delusions (order started 5/1/12); and warfarin (anticoagulant) 3 mg every day for a diagnosis of CVA (order started 10/30/14). R2 was periodically observed from 12/9/14 through 12/11/14, with no evidence of bruising, bleeding, behaviors or possible psychotropic medication side effects noted. The Psychotropic Drug Use care plan edited 10/18/14, indicated R2 received Zyprexa for depression, had a history of suicidal attempts and a goal of not harming himself. The care plan directed staff monitoring R2 for behaviors that were not customary such as; a loss of interest to read, attend activities and or attend social events; and verbal or physical aggression. The care plan did not identify monitoring for potential risks, side effects or effectiveness of Zyprexa. Further the care plan did not identify the use or monitoring potential adverse consequences for anticoagulant and antidepressant medications. On 12/11/14, at 9:45 a.m. the director of nursing (DON) verified that warfarin and the antidepressant were not addressed on the care plan. The DON stated there was no evidence of monitoring potential side effects of anticoagulant medication. The DON stated monitoring for the	2 560	Administration Record. Resident R32□s plan of care has been revised and updated to include interventions for monitoring for potential risks and side effects from hypnotic, antianxiety, and antidepressant medication use in the Medication Administration Record. D. The plan of care for all current residents have been reviewed for appropriate interventions and revisions that include monitoring for side effects, efficacy, and/or target behaviors and added if necessary. E. All Licensed Nursing Staff have been educated on December 29, 2014 on updating/revision of the resident plan of care should a psychotropic medication be prescribed for a resident within the facility. F. The Director of Nursing or designee will audit weekly for the proper care planning of psychotropic drug use and audit findings will be reported to Quality Assurance for ongoing monitoring. G. Correction Date: 01/09/2015	

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2 560	Continued From page 3	2 560		

warfarin was done in the progress notes when the INR (International Normalized Ratio, a blood test to ensure the medication was working properly) was done.

R32's care plan did not address assessed needs, interventions or approaches related to hypnotic, antidepressant and anti-anxiety medications.

R32 was admitted on 10/19/14. The admission Minimum Data Set (MDS) dated 10/28/14, indicated R32 was cognitively intact and had diagnoses including hypertension, anxiety disorder and depression.

The psychotropic drug care area assessment (CAA) dated 10/28/14 indicated R32's was unable to sleep at night and was taking antianxiety, antidepressant, and sedative/hypnotic medications.

R32's physician medication orders current in the electronic health record indicated Ambien (hypnotic medication) 5 milligrams (mg) by mouth for insomnia at bedtime; Celexa (antidepressant) 20 mg by mouth at bedtime; and Ativan (antianxiety medication) 0.5mg by mouth for anxiety once a day.

The DON, interviewed on 12/11/14, stated verified R32 was taking all three medications and the interventions and monitoring for insomnia, depression and anxiety should be on the care plan but were not.

The facility's Comprehensive Care Plans policy dated 5/8/13, identified comprehensive care plans were developed and revised based on resident assessment and included services that were to be furnished to attain or maintain the resident's

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2 560	Continued From page 4 highest practicable physical, mental and psychosocial well-being. R32's care plan did not address assessed needs, interventions or approaches related to hypnotic, antidepressant and anti-anxiety medications. R32 was admitted on 10/19/14. The admission Minimum Data Set (MDS) dated 10/28/14, indicated R32 was cognitively intact and had diagnoses including hypertension, anxiety disorder and depression. The psychotropic drug care area assessment (CAA) dated 10/28/14 indicated R32's was unable to sleep at night and was taking antianxiety, antidepressant, and sedative/hypnotic medications. R32's physician medication orders current in the electronic health record indicated Ambien (hypnotic medication) 5 milligrams (mg) by mouth for insomnia at bedtime; Celexa (antidepressant) 20 mg by mouth at bedtime; and Ativan (antianxiety medication) 0.5mg by mouth for anxiety once a day. The DON, interviewed on 12/11/14, stated verified R32 was taking all three medications and the interventions and monitoring for insomnia, depression and anxiety should be on the care plan but were not. The facility's Comprehensive Care Plans policy dated 5/8/13, identified comprehensive care plans were developed and revised based on resident assessment and included services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.	2 560		

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2 560	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the development of care plans on all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 830	A. It is Facility practice to seek outside	1/9/15

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2 830	Continued From page 6 review, the facility failed to comprehensively assess, identify, implement and monitor effective behavioral interventions for 1 of 1 resident (R15) who demonstrated verbally and physically aggressive behaviors directed toward others. Findings include: R15's nurse Practioner (NP)-A note dated 9/10/14, identified diagnoses including depression, aphasia and history of a large, left-middle cerebral artery Cerebrovascular accident (CVA/ stroke) in 9/13. The progress note indicated, R15's "Depression... appears to be controlled at this point and he has not had any recent aggressive behaviors towards staff or other residents... He is currently on citalopram [Celexa, an antidepressant medication] and this appears to be working well for him." The quarterly Minimum Data Set (MDS) dated 10/8/14, identified R15 had unclear speech and sometimes understood simple, direct communication from others. R15 had severely impaired cognition, with inattention and disorganized thinking. The MDS identified R15 with verbal behavioral symptoms directed toward others, including threatening, screaming or cursing at others. No physical behavioral symptoms were identified. R15 was noted as independent with locomotion on the unit and required limited assistance for transfers and ambulation. The Care Area Assessment (CAA) dated 1/7/14, noted R15 became angry/frustrated and yelled or hollered out for staff or at staff due to inability to express himself clearly. The CAA noted, "Resident has not attempted to physically harm self or others. Out of frustration, due to	2 830	behavioral consulting services for residents displaying behavioral concerns. B. Referral for resident R15 has been made for outside consulting services. C. Resident R15 has an updated aggressive behavior monitoring program in place. D. Facility wide audit for all residents completed to review behavioral needs and if appropriate behavioral monitoring interventions implemented. E. The Director of Social Services will review behavioral notes and concerns within 24-72 hours. F. The Director of Social Services or designee will audit weekly to ensure that the proper follow-up regarding behavioral concerns and use of behavioral consulting services as necessary. Administrator will audit for proper follow-up regarding behavioral concerns and the use of behavioral consulting services as necessary. G. Correction Date: 01/09/2015	

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2 830	Continued From page 7 inability to verbalize needs, has physically refused cares by staff due to mis-communication. No potential for harm to self or others." The medical record lacked evidence of a comprehensive evaluation of behavioral patterns, antecedents/historical triggers, baseline frequency, baseline intensity and interventions attempted but failed. R15's care plan revised 11/7/14, R15's care plan revised 11/7/14, noted, "[R15] shows negative aggression towards staff and residents. Triggering factors such as environment, staff member approach, exiting of visitors... [R15] will be able to decrease the number of negative physical behaviors by 1 [one] a week... [R15] will be able to avoid a physical aggressive response towards staff and residents." Interventions included the following: Use of a positive approach during cares, explaining and showing R15 what was needed; Use of positive reinforcement of good behaviors through verbal praise; Documenting triggers, such as the environment, staff approach, exiting of visitors, or doing cares, and; Use of redirection to diffuse anger in a positive way. The care plan also noted, "[R15] has difficulty communicating and making self understood d/t [due to] impaired cognition. Speech is garbled most of the time, which can lead to social isolation." Interventions included visits by volunteers, informing him of upcoming activities, involving him with others who had shared interests, providing one-to-one sessions and providing him with (unidentified) materials of interest. Additional interventions for R15 included allowing extra time for self-expression and periodic approaches to ensure routine needs were met. R15's progress notes dated 9/11/14, through	2 830		

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2 830	Continued From page 8 12/11/14, revealed repeated incidents of aggressive behavior with ineffective intervention attempts. R15's aggressive behaviors included cursing, running wheelchair into others, screaming, shaking his closed fist at staff, verbal threats to kill others, hitting/kicking walls/wall hangings and physically assaulting staff. The medical record lacked evidence of systematic behavior monitoring to determine antecedents, specific behaviors or effectiveness of attempted interventions. Nursing notes on 10/25/14, at 2:37 p.m. indicated R15 became very angry when other [unidentified] resident told them to please stay out of their stuff. R15 took bag of candy from other resident's dresser drawer. Staff were called into the room by call light and R15 became verbally aggressive with resident and staff. Nursing notes on 11/21/14, at 3:29 p.m. indicated R15 was swearing in hallway and didn't want to let [two residents] out of their bedroom. All behavior monitoring for R15 during the period of 9/11/14, through 12/11/14, was requested for review. The following documentation was provided in addition to the progress notes above: · On 10/5/14, R15's behavior documentation described verbal and physical abuse directed toward others and rejection of care. The behaviors placed R15 at significant risk for physical injury; significantly interfered with resident care and participation in activities or social interactions; placed others at significant risk for injury; intruded on the privacy or activity of others; and significantly disrupted care or living environment. Behavior interventions attempted included redirection, offering of food/fluids, one-to-one time with staff and returning R15 to	2 830		

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2 830	Continued From page 9 his room. R15's behaviors were noted as easily altered with implementation of these interventions. On 12/6/14, the behavioral documentation noted R15 wandered and was verbally abusive which significantly interfered with care and participation in social activities and disrupted the living environment within the facility. · Daily Stand Up/Medicare Meeting notes from 12/8/14, through 12/11/14, indicated behavior concerns for each resident were discussed on a daily basis. The notes lacked detail of behaviors or effectiveness of attempted interventions. There was no cumulative evaluation of antecedents, description of R15's behaviors or effectiveness of attempted interventions. During intermittent observations throughout the survey period on 12/8/14, from 1:00 p.m. to 8:00 p.m., on 12/9/14, from 8:00 a.m. to 5:30 p.m., on 12/10/14, from 7:00 a.m. to 3:30 p.m. and on 12/11/14, from 8:00 a.m. to 5:00 p.m., R15 wandered up and down the hallway, self-propelling in his wheelchair. R15 was not observed to be physically aggressive or threatening but called out loudly. R15 was noted as a tall male with broad shoulders and a strong appearance. During observation of the evening meal on 12/8/14, at 5:40 p.m. R15 entered the dining room, self-propelling his wheelchair. R15 was unable to make his way to his place setting at the far side of one of the dining room tables because of limited space between the table and R28, who was seated in her wheelchair at the neighboring table. R15 persisted with self-propelling through the narrow space, repeatedly pushing into another resident's wheelchair with his own wheelchair. Several staff in the area, along with	2 830		

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2 830	Continued From page 10 the residents at the neighboring table told him to hold on, be patient and wait for the staff to move the table so he would have enough room to maneuver to his place setting. R15 then became visibly upset, yelled out and abruptly shoved the table and a chair. His speech was unintelligible, with a loud volume and gruff tone. During interview on 12/10/14, at 12:14 p.m. RN-A confirmed R15 did hit staff if they were trying to get him to do something he did not want to do. She reported staff reassured other residents by telling them it would not last long, not to engage with him and it would pass. During interview on 12/10/14, at 12:20 p.m. NA-H said it was hard to say whether R15 would have targeted another resident when he got angry. NA-H reported the facility had instructed staff to tell other residents to just ignore/ avoid R15 and let the staff deal with him. During interview on 12/11/14, at 10:34 a.m. social service director (SSD) denied knowledge of R15 physically or verbally aggressing toward other residents. She indicated R15's interdisciplinary team was currently working on developing interventions to address R15's behaviors. SSD gave examples of current behavior interventions including the following: ensuring his needs were met (i.e. toileting), offering him coffee, informal one-to-one visits with herself and other administrative staff in the office area of the facility and encouraging activities of interest to him. She added, "We try to calm him down, see if he needs anything ... We just try to talk him down, sometimes it is successful, sometimes it just isn't." SSD was unable to offer an estimate of the level of success with implementation of current redirection techniques for R15's behaviors. She	2 830		

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2 830	Continued From page 11 stated, "He does not seem to understand inability for immediate gratification of what he wants ... Trying to communicate his needs is a trigger." SSD reported she had only been in the social service role for approximately one and one-half month. During interview about facility interventions to address R15's behaviors on 12/11/14, at 2:44 p.m. the stated they consulted with another facility that typically provided services for individuals similar to R15, seeking ideas for how they educated their staff in recognizing and identifying behavior triggers and age appropriate responses to the behaviors. The IDT also conducted some research on the cognitive and behavioral effects of a stroke. She added facility staff had received several training on these topics as a result of these resources. The administrator reported the IDT sought contact with a family member who was able to share some of R15's social history to provide a baseline. R15's spouse was also able to share his likes and preferences, helping facility staff to be more proactive, instead of reactive. In addition, the administrator reached out to the consultant pharmacist and nurse practitioner to consider medication management options for assistance in management of his behaviors. The administrator reported behavior management techniques were expected of staff in their support of R15, including, "When he is having behaviors, do not argue... let him be... remove others from the area... do not try to move him." She also reported the staff were to provide him with attention, letting him know they would be right back, avoiding certain terminology found to trigger inappropriate behavior, such as saying "goodbye." The facility's undated, Dealing with Residents	2 830		

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2 830	Continued From page 12 who have Aggressive, Demanding and/or Difficult Behavior policy instructed all residents were to be protected from abuse and staff were to be educated on dealing with difficult, demanding and aggressive behavior. Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to the developement and implementation of effective behavioral interventions. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance. Time period for correction: Twenty one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		1/9/15

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21426	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure employees received the 2 step tuberculin skin test (TST) for 3 of 5 employees (NA-B,NA-B,NA-D) reviewed and failed to ensure residents received a TST within 3 days of admissions 1 of 5 resident (R30) and failed to ensure that a 2nd TST was completed for 1 of 5 residents (R19) reviewed. Findings include: The undated MANTOUX (TST)/TUBERCULOSIS SCREENING/DIAGNOSED TUBERCULOSIS, indicated all first time residents will be screened for infection with tubercele bacilli within 72 hours of admisstion. Skin testing will employ the two step procedure. A second test will be give 1-3 (7-21 days) weeks later. New employees will recieve a two-step TST when they start. A reviesed TB Policy updated 12/3/14 indicated all resident will be screened within 72 hours and a second test will be given 2 weeks later. Employees will recieve there test upon start of employment. NA-B was hired on 10/2/14. NA-B recieved his first TST on 11/1/14, a second TST was not given until 12/7/14. NA-C was hired 10/28/14. NA-B received her first TST on 11/1/14, a 2nd TST was not given until 12/2/14. NA-D was hired 10/5/14. NA-D recieved her first TST on 10/2/14. There is no documentation	21426	4658.0810 A. It is the policy of this facility to complete timely 2-step tuberculin skin testing and screening on all employees and admitted residents. Resident R19 has expired 12/21/2014. A copy of R19□s previous tuberculin skin test documentation was obtained and placed in the resident file and TB tracking binder. Resident R30□s 1st tuberculin skin test was completed 12/19/2014 and the 2nd step was completed 12/30/2014, all documentation was obtained and placed in the resident file and TB tracking binder. B. The facility□s policy and procedure has been reviewed. C. Files of all employees and residents for 2014 have been audited to ensure 2-step tuberculin skin testing documentation and annual assessments are complete and placed in personnel file, resident chart, and TB tracking binder. D. Audits of all newly hired and newly admitted residents will be completed to assure that 2-step tuberculin testing and documentation is complete and filed in employee□s personnel file and resident□s chart and TB tracking binder. To ensure the timeliness of tuberculin skin testing and annual assessment, results of these audits will be reviewed weekly at management meetings and quarterly during Quality Assurance meetings for accuracy, timeliness, and/or any further	

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21426	Continued From page 14 indicating a 2nd TST was completed. R30 was admitted to the facility on 8/19/2014. R30 did not recieve her first TST until 9/29/14. R19 was admitted to the facility on 10/1/2014, R30 recieved his first TST on 10/15/15, there is no documentation indicating a 2nd TST was completed. During an interview on 12/10/14, at 12:10 p.m. registered nurse (RN)-A stated R30 had not received the TST within 72 hours of admission. R19's medical record lacked documentation that a 2nd TST was completed. RN-A verified the findings. On 12/11/14, at 1:20 p.m. during an interview with the director of nursing (DON) who verified that the TST's were not completed for residents R30 and R19. and employees NA-B, NA-C, NA-D. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the assessment process for residents and employees to be sure they have the two-step tuberculin test completed, the administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426	action. E. The Director of Nursing or her designee will be responsible for completion and timeliness of 2-step tuberculin skin testing and annual assessments for employees and residents. F. Correction date: December 29, 2014	
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment,	21880		1/9/15

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21880	Continued From page 15 to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act on resident complaints, for 1 of 1 resident (R13) who expressed complaints of his roommate's behavior and requested a new room assignment. Findings include: R13, interviewed on 12/8/14, at 4:48 p.m., stated, "The administration could stand to watch [his roommate] sometimes and see how he treats others." R13 stated the roommate appeared somewhat threatening and added, "Let me put it this way, I don't trust him..." R13 stated some of the nursing assistants (NAs) were aware of how he felt, but he had not reported it to licensed staff or administration. R13's admission Minimum Data Set (MDS) dated 11/17/14, identified moderate cognitive impairment. R13's Resident Progress Note authored by licensed practical nurse (LPN)-F dated 12/5/14, at 6:36 p.m. noted, "Wants to switch rooms due to another res [resident's] behaviors, [R13] did not want to go in his room after supper due to other res [resident's] behaviors, he went [and] sat in TV rm [television room] instead." No follow-up was completed for R13's request for a room change. During interview on 12/11/14, at 10:34 a.m. social service director (SSD) confirmed she handled all resident room change requests. SSD denied knowledge of R13's request to change rooms. Upon review of R13's 12/5/14, progress note SSD confirmed LPN-F should have forwarded the	21880	A. It is the Facility practice to acknowledge and act on resident/family concerns. B. The facility□'s grievance/concern policy has been revised and reviewed for appropriateness. C. All staff members will be educated about revision of the policy and the proper chain of communication regarding registering a resident/family member concern. All concerns will be given to the Administrator. D. Resident R13 was offered a room change and has since moved rooms. E. Follow-up audits of resident/family concerns will be completed daily for two weeks, then weekly for one month by the Director of Social Services. The need for ongoing monitoring of resident/family concerns will be determined by the Quality Assurance Committee. F. Correction Date: December 30, 2014	

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21880	Continued From page 17 request to her for follow-up. The director of nurses (DON) was interviewed on 12/11/14, at 2:28 p.m. and stated the facility's process to address resident complaints was to report "up the chain of command." She confirmed that a resident's request for room change as well as complaints of another resident's behavior should be addressed. The DON confirmed she was not informed of R13's concern about the room mate or request for a room change. The facility's undated Complaint/Concern Policy noted residents and/or their legal representative were encouraged to exercise their rights by presenting complaints or concerns on behalf of themselves or others in effort to improve resident care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies pertaining to handling resident grievances, educate staff on these policies and perform audits to ensure each resident grievance has been addressed by the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		