#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 2GXG

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

	PART I - TO BE COMPLETED BY THE					STATE SURVEY AGENCY Facility ID: 00588			
MEDICARE/MEDICAID PROVIDER N     (L1) 245125  2.STATE VENDOR OR MEDICAID NO.     (L2) 112847700	О.	3. NAME AND ADDRESS OF FACILITY (L3) FITZGERALD NH AND REHAB (L4) 227 MCKINLEY AVENUE (L5) EVELETH, MN			(L6) 55734		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7(L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWN (L9) <b>07/22/2014</b>		7. PROVIDER/SUI	PPLIER CATEGOR	Y 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other omplaint	
6. DATE OF SURVEY 01/26  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	24 (L18) 24 (L17)	B. Not in Com	nce With	n	2. Techn3. 24 Ho4. 7-Day5. Life S	ical Personnel our RN RN (Rural SNF)	- 6. Scope of Servi - 7. Medical Direc - 8. Patient Room (19) Beds/Room	tor	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY MEI 1861 (e) (1) or 18		(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	LATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY API	PROVAL	Date:	
Christine Campbell,	Unit Superv	visor	02/13/2015	(L19)	Mark	Meath	, Enforcement Specia	02/26/2015 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SI	INGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Part      2. Facility is not Eligible	ticipate		IPLIANCE WITH C HTS ACT:	CIVIL	2. Ov		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)	
	(L21)				I				
22. ORIGINAL DATE  OF PARTICIPATION  05/15/1967	23. LTC AGREEMI BEGINNING		24. LTC AGREEMI ENDING DAT		26. TERMINATION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction	<u>00</u>	INVOLUN' 05-Fail to M	L30)  FARY eet Health/Safety eet Agreement	
(L24) 25. LTC EXTENSION DATE:	(L41)  27. ALTERNATIVI  A. Suspension (	of Admissions:	(L25) (L44)		03-Risk of Involunt 04-Other Reason fo	•	<u>OTHER</u>	Status Change	
(L27)	B. Rescind Sus	pension Date:	g 45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45)		30. REMARKS				
		00000							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	TE					
	(L32)	01/22/2015		(L33)	DETERMINAT	ΓΙΟΝ APPRO'	VAL		



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 Weath

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 Weath

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

Form Approved
OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245125	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/26/2015
Name	of Facility		Street Address, City, State, Zip Code	
FIT	ZGERALD 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	()	(5) Date	(Y4)	Item	(Y5)	Date
		Correction			Correction				Correction
ID Deefin	F0400	Completed	ID Deefin	F00F0	Completed		ID Deefin	F0070	Completed
ID Prefix		_01/09/2015	ID Prefix		01/09/2015		ID Prefix		01/09/2015
•	483.10(f)(2)	_		483.15(g)(1)	_			483.20(d), 483.20(k)(1)	_
		_							_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0309	01/26/2015	ID Prefix				ID Prefix		
Reg. #	483.25	_	Reg. #				Reg. #		
LSC		_	LSC		_		LSC		_
		Competion			Composition				Camaatian
		Correction Completed			Correction Completed				Correction Completed
ID Prefix		_ Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #				Reg. #		
LSC			LSC		<del></del>		LSC		<u> </u>
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #		_	Reg. #						
		_ _			<u> </u>		LSC		<u> </u>
									- "
		Correction Completed			Correction Completed				Correction Completed
ID Prefix		Completed	ID Prefix				ID Prefix		Completed
Reg. #			Reg. #				Reg. #		
LSC		_	LSC		_		LSC		_
Reviewed By	Reviewed	Ву	Date:	Signature of Su	rveyor:			Date:	
State Agency	, CC/m	ım	02/2620	15	13922			01/2	26/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Su	rveyor:			Date:	
CMS RO									
Followup to	Survey Completed on:				ny Uncorrected			<u>-</u>	
	12/11/2014			Uncorre	cted Deficiencie	s (CMS	6-2567) Sent	to the Facility? YES	NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: 2GXG Facility ID: 00588

		Г					-
MEDICARE/MEDICAID PROVIDE     (L1) 245125      2.STATE VENDOR OR MEDICAID N     (L2) 112847700		3. NAME AND AL (L3) FITZGERA (L4) 227 MCKIN (L5) EVELETH,	LD NH AND F LEY AVENUE	REHAB	(L6) <b>55734</b>	4. TYPE OF ACTI  1. Initial 3. Termination 5. Validation	ON: <u>2 (</u> L8)  2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) <b>07/22/2014</b>	DWNERSHIP  1/2014 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF		GORY  09 ESRD  10 NF  11 ICF/III  12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 8. Full Survey Aft FISCAL YEAR END 02/28	9. Other er Complaint
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	24 (L18) 24 (L17)	Complianc1. A  X B. Not in Con	equirements ee Based On: acceptable POC	gram	And/Or Approved Waivers Of  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code  * Code: <b>B</b> *	6. Scope of S 7. Medical D	ervices Limit irector om Size
14. LTC CERTIFIED BED BREAKDO  18 SNF 18/19 SNF  24  (L37) (L38)	WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):			
17. SURVEYOR SIGNATURE  Kathie Killoran, HFE NE I	I	Date :	12/31/2014	(L19)	18. STATE SURVEY AGENCY Anne Kleppe, Enforce		Date: 01/15/2015
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	` ′	L OFFICE OR SINGLE S	STATE AGENCY	(L20)
DETERMINATION OF ELIGIBIL	ITY 'articipate	20. COM	IPLIANCE WITH		21. 1. Statement of Fina	ancial Solvency (HCFA-25 ol Interest Disclosure Strr	
22. ORIGINAL DATE  OF PARTICIPATION  05/15/1967  (L24)  25. LTC EXTENSION DATE:  (L27)		DATE	4. LTC AGREEN ENDING DA' (L25) (L44) (L45)		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimburs  03-Risk of Involuntary Termination  04-Other Reason for Withdrawal	0         INVOLU           05-Fail to         06-Fail to           on         OTHER	o Meet Health/Safety o Meet Agreement  der Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
	(L28)	00000		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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:

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

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

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

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

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

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

#### **DEPARTMENT CONTACT**

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 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

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

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		245125	B. WING _		12/11/2014
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 227 MCKINLEY AVENUE EVELETH, MN 55734	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
F 000	INITIAL COMMENT	rs	F 00	00	
	WILL SERVE AS Y COMPLIANCE UPO ACCEPTANCE. YO BOTTOM OF THE CMS-2567 FORM VERIFICATION OF UPON RECEIPT CONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO	F COMPLIANCE.  OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE			
		AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
F 166 SS=D	extended survey w 12/11/14. 483.10(f)(2) RIGHT RESOLVE GRIEVA	•	F 16	66	1/9/15
	facility to resolve gi	right to prompt efforts by the rievances the resident may se with respect to the behavior			
LABORATOR	by: Based on interview facility failed to act of 1 resident (R13) his roommate's be room assignment.	NT is not met as evidenced v and document review, the on resident complaints, for 1 who expressed complaints of havior and requested a new	MATURE	F166 A. It is the Facility practice to acknowledge and act on resident/ concerns. B. The facility's grievance/conce	

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 Signed** 

12/31/2014

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVI	
		245125	B. WING			12/1	1/2014
	PROVIDER OR SUPPLIER	3		22	TREET ADDRESS, CITY, STATE, ZIP CODE 7 MCKINLEY AVENUE VELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	"The administration roommate] sometin others." R13 stated somewhat threater this way, I don't tru the nursing assistate felt, but he had or administration.  R13's admission M 11/17/14, identified impairment.  R13's Resident Prolicensed practical r6:36 p.m. noted, "Vanother res [resident want to go in his rores [resident's] beham [television room completed for R13]  During interview or service director (S resident room chaknowledge of R13' Upon review of R1 confirmed LPN-F strequest to her for the director of nur 12/11/14, at 2:28 process to address report "up the chairs."	n 12/8/14, at 4:48 p.m., stated, n could stand to watch [his mes and see how he treats of the roommate appeared hing and added, "Let me put it st him" R13 stated some of ents (NAs) were aware of how not reported it to licensed staff.  Inimimum Data Set (MDS) dated it moderate cognitive.  Digress Note authored by hurse (LPN)-F dated 12/5/14, at Wants to switch rooms due to ent's] behaviors, [R13] did not boom after supper due to other haviors, he went [and] sat in TV in instead." No follow-up was 's request for a room change.  In 12/11/14, at 10:34 a.m. social SD) confirmed she handled all inge requests. SSD denied is request to change rooms. 3's 12/5/14, progress note SSD should have forwarded the		166	has been revised and reviewed for appropriateness.  C. All staff members will be educa about revision of the policy and the chain of communication regarding registering a resident/family member concern. All concerns will be given Administrator.  D. Resident R13 was offered a rocchange and has since moved room E. Follow-up audits of resident/famiconcerns will be completed daily for weeks, then weekly for one month I Director of Social Services. The neongoing monitoring of resident/famiconcerns will be determined by the Assurance Committee.  F. Correction Date: 01/09/2015	er to the om s. nily r two by the eed for ily	

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	as complaints of a should be address; was not informed or room mate or required. The facility's undat noted residents and were encouraged to presenting complainthemselves or other care.  483.15(g)(1) PROVELATED SOCIAL	nother resident's behavior ed. The DON confirmed she of R13's concern about the est for a room change.  ed Complaint/Concern Policy d/or their legal representative of exercise their rights by ints or concerns on behalf of ers in effort to improve resident of exercise their rights by ints or concerns on behalf of ers in effort to improve resident of exercise their rights by ints or concerns on behalf of ers in effort to improve resident of exercise their rights by ints or concerns on behalf of ers in effort to improve resident of exercise their rights are interested in the highest all, mental, and psychosocial	F 1			1/9/15
	by: Based on observareview, facility soci provide consultativ behavioral concerreviewed for verbareviewed for verbarevie	NT is not met as evidenced tion, interview and document al service staff did not refer or e services to address as for 1 of 1 resident (R15) l/physical aggression.  Oner (NP)-A note dated diagnoses including ia and history of a large, al artery Cerebrovascular oke) in 9/13.  mum Data Set (MDS) dated		F250 A. It is Facility practice to s behavioral consulting service residents displaying behavion B. Referral for resident R15 made for outside consulting C. Resident R15 has an upaggressive behavior monitor in place. D. Facility wide audit for all completed to review behavior if appropriate behavioral mointerventions implemented. E. The Director of Social S review behavioral notes and	es for or or of the services. The services of the services of the services or of the services or of the services will or of the services will or of the services will or of the services	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 250	10/8/14, identified cognition, inatten The MDS identifications includ cursing directed assessment (CA became angry/frodue to inability to R15's care plan in following behavior positive approach showing R15 who reinforcement of praise; Documer environment, standing cares, and anger in a positive "[R15] has difficuself understood aspeech is garble lead to social isovisits by volunted activities, involving shared interests, and providing him Additional interventational interventation of the search of the	page 3 d R15 with severely impaired tion and disorganized thinking. ed R15 with verbal behavioral ing threatening, screaming or toward others. The Care Area A) dated 1/7/14, noted R15 ustrated and yelled or hollered express himself clearly.  Tevised 11/7/14, directed the oral interventions: Use of a n during cares, explaining and at was needed; Use of positive good behaviors through verbal ating triggers, such as the ff approach, exiting of visitors, or; Use of redirection to diffuse way. The care plan also noted, alty communicating and making d/t [due to] impaired cognition. In the time, which can alation." Interventions included ers, informing him of upcoming him with others who had providing one-to-one sessions in with materials of interest. The entitions for R15 included allowing alf-expression and periodic ensure routine needs were met.  Though the desired incidents of the time of the time of the time of the entitions of the entit		within 24-72 hours. F. The Director of Social Sidesignee will audit weekly to the proper follow-up regard concerns and use of behaviores as necessary. Adraudit for proper follow-up rebehavioral concerns and the behavioral consulting services necessary. G. Correction Date: 01/09	to ensure that ding behavioral vioral consulting ministrator will egarding ne use of ces as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 250	physical abuse direabuse directed tow care. The behavior for physical injury, resident care, signiparticipation in actiplaced others at sign on the privacy or asignificantly disrupt On 12/6/14, behav wandering and verabusive behaviors significantly disrupt within the facility.  During intermittent survey period on 1 p.m., on 12/9/14, fin 12/10/14, from 7:0 12/11/14, from 8:00 wandered up and continued to speak hand of the person observed to be phythreatening but calfoliow people off the younger male (application) and self-propelling in the surveyor walked by his hand out. Whe continued to speak hand of the person observed to be phythreatening but calfoliow people off the younger male (application) and shoulders at During observation 12/8/14, at 5:40 p. wheelchair into the to make his way to of one of the dining	e History on 10/5/14, identified ected toward others, verbal ard others and rejection of s placed R15 at significant risk significantly interfered with ficantly interfered with his vities or social interactions, gnificant risk for injury, intruded ectivity of others and eled care or living environment. For injury, intruded bal abuse toward others. R15's toward others were noted to a care of living environment.  Observations throughout the 2/8/14, from 1:00 p.m. to 8:00 rom 8:00 a.m. to 5:30 p.m., on 0 a.m. to 3:30 p.m. and on 0 a.m. to 5:00 p.m., R15		250			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		4	(X3) DATE SURVEY COMPLETED	
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F 250	persisted with self- space, repeatedly wheelchair. Severa to be patient and w table to make roor upset, yelled out a and a chair.  The administrator, on 12/9/14, at 3:57 developed on how to manage R15's k involved in recome adjustments, and  During interview o nursing assistant ( instructed staff to ignore/avoid R15 a  During interview o activities director ( activities where R of time. She states span." AD reporte structured or form R15, but did try to he looked bored o distraction. AD rep included staff bein the attention that k  During interview o service director (S physically or verba residents. She ad see if he needs ar	neighboring table. R15 propelling through the narrow pushing into the resident's al staff in the area and told R15 vait for the staff to move the n to pass. R15 was visibly nd abruptly shoved the table  interviewed about staff training p.m., stated a plan was being to proceed, staff were trained behavior, the pharmacist was mending medication NP-A was also involved.  n 12/10/14, at 12:20 p.m. NA)-H reported the facility had tell other residents to just and let staff deal with him.  n 12/11/14, at 8:35 a.m. AD) reported there were few 15 remained for any real length d, "He has a very short interest d she did not have any al one-to-one activity times with do one-to-ones with him when r appeared to be in need of a ported R15's behavior triggers ng too busy to stop and give him		250			

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F 250	just isn't." SSD was the level of succes current redirection behaviors. She sta understand inability what he wants T needs is a trigger." been in the social s one and one-half n  During interview or director of nursing no referral to outsic adjusting medication referral to geriatric  During interview or administrator ident interventions include care home, seekin interventions from The IDT also cond cognitive and behat administrator repo member who was social history to provide a social history to provide a social history was also able to sh helping facility staff of reactive. In addi out to the consultat practitioner to consoptions for assistat behaviors.  The facility's undar who have Aggress Behavior policy ins protected and staff	s unable to offer an estimate of s with implementation of techniques for R15's ted, "He does not seem to y for immediate gratification of rying to communicate his SSD reported she had only service role for approximately		250		

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	ge 7	F2	250				
483.20(d), 483.20(k		F2	279			1/9/15	
to develop, review a	and revise the resident's						
plan for each reside objectives and time medical, nursing, a	ent that includes measurable stables to meet a resident's nd mental and psychosocial		;				
to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including	attain or maintain the resident's physical, mental, and peing as required under services that would otherwise §483.25 but are not provided a exercise of rights under the right to refuse treatment						
by: Based on observareview, the facility for monitoring potentiatarget behaviors or residents (R2, R32 medications.  Findings include:	tion, interview and document failed to develop a care plan for al side effects, efficacy and/or f medications for 2 of 6 ) reviewed for unnecessary			of care to include resident monitoring side effects, efficacy, and/or target behaviors.  B. Facility wide audit completed to ensure that the resident plan of carrincludes resident monitoring for sidents.	ng for o e e		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM PREHENSIVE A facility must use to develop, review a comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, an eeds that are idented assessment.  The care plan must to be furnished to a highest practicable psychosocial well-by \$483.25; and any seeds that are idented to the resident \$483.10, including under \$483.10, including under \$483.10(b)(4).  This REQUIREME by: Based on observative review, the facility from the facilit	behavior.  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.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7 behavior.  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).  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F 279	10/21/14, identified impairment. The M symptoms of deliribehaviors; had dia depression and Ce and received antipanticoagulant med days during the as  The signed Physic included paroxetin once daily for depr Zyprexa (antipsychementia with deluand warfarin (antic diagnosis of CVA (R2 was periodicall through 12/11/14, bleeding, behavior medication side ef  The Psychotropic 10/18/14, indicated depression, had a a goal of not harm directed staff to mwere not customai read, attend activitiand verbal or physicare plan indicated gradual dose reducare plan did not icrisks, side effects Paxil or anticoagu	d R2 had moderate cognitive IDS indicated R2 had no um or depression; had no gnoses of dementia, erebrovascular accident (CVA); sychotic, antidepressant and ication seven out of seven sessment period.  ian Orders dated 11/26/14, e (Paxil) 20 milligrams (mg) ression (order started 5/1/12); notic) 5 mg at bedtime for isions (order started 5/1/12); roagulant) 3 mg every day for a order started 10/30/14).  by observed from 12/9/14 with no evidence of bruising, is or possible psychotropic fects noted.  Drug Use care plan edited d R2 received Zyprexa for history of suicidal attempts and ing himself. The care plan onitor R2 for behaviors that my such as; a loss of interest to the sand or attend social events; sical aggression. In addition the d R2 had failed past attempts of ctions for the Zyprexa. The dentify monitoring for potential or effectiveness of Zyprexa, lant medications.		279	C. Resident R2□s plan of care harevised and updated to include interventions for monitoring for potrisks and side effects from Zyprexand anti-coagulant use in the Medi Administration Record. Resident I plan of care has been revised and updated to include interventions for monitoring for potential risks and seffects from hypnotic, antianxiety, antidepressant medication use in the Medication Administration Record. D. The plan of care for all current residents have been reviewed for appropriate interventions and revist that include monitoring for side effection efficacy, and/or target behaviors an added if necessary.  E. All Licensed Nursing Staff have educated on December 29, 2014 of updating/revision of the resident potare should a psychotropic medical prescribed for a resident within the F. The Director of Nursing or desivill audit weekly for the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of psychotropic drug use audit findings will be reported to Question and the proper car planning of	ential a, Paxil, cation R32 s  r side and he sions ects, nd lan of ation be e facility. signee e and uality	

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F 279	antidepressant w plan. The DON s monitoring potent medication.  R32's care plan of interventions or a antidepressant at R32 was admitted Minimum Data S indicated R32 was diagnoses included disorder and deput The psychotropic (CAA) dated 10/2 to sleep at night antidepressant, a medications.  R32's physician relectronic health	ere not addressed on the care tated there was no evidence of tial side effects of anticoagulant did not address assessed needs, approaches related to hypnotic, and anti-anxiety medications.  d on 10/19/14. The admission et (MDS) dated 10/28/14, as cognitively intact and had ing hypertension, anxiety		79		
	for insomnia at b 20 mg by mouth (antianxiety med anxiety once a day once a d	edtime; Celexa (antidepressant) at bedtime; and Ativan ication) 0.5mg by mouth for ay.  iewed on 12/11/14, stated verified all three medications and the dimonitoring for insomnia, anxiety should be on the care				

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F 279	highest practicable psychosocial well-l	ain or maintain the resident's physical, mental and peing. CARE/SERVICES FOR	F 279		1/9/15
	provide the necess or maintain the hig mental, and psych	st receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in he comprehensive assessment			
	by: Based on observareview, the facility assess, identify, in behavioral interver who demonstrated aggressive behavioral include:  R15's nurse Pract 9/10/14, identified depression, aphase left-middle cerebraticident (CVA/ struction indicated, R1 be controlled at the recent aggressive other residents	ation, interview and document failed to comprehensively applement and monitor effective ations for 1 of 1 resident (R15) I verbally and physically ors directed toward others.  ioner (NP)-A note dated diagnoses including sia and history of a large, al artery Cerebrovascular oke) in 9/13. The progress 5's "Depression appears to is point and he has not had any behaviors towards staff or the is currently on citalopram pressant medication] and this king well for him "		F309 A. It is facility practice to complete comprehensive assessment for all residents. All residents will have a rof necessary behavioral intervention effectiveness included in the assess Facility sprocedure for comprehen assessments have reviewed and revises. Upon return to the facility, residents will have a comprehensive assessment completed and care plaber eviewed and revised. C. All staff responsible for complete comprehensive resident assessment have been educated to the procedurative the requirements for a complete comprehensive assessment, including ongoing monitoring and effectiveness of resident care planne effectiveness of resident care planne	eview is and sment. sive vised. ent an will ing its re and ing iss. will and

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	PROVIDER OR SUPPLIER			2:	TREET ADDRESS, CITY, STATE, ZIP CODE 27 MCKINLEY AVENUE VELETH, MN 55734	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	10/8/14, identified sometimes unders communication from impaired cognition disorganized think with verbal behavior others, including the cursing at others. Symptoms were idented independent with I required limited as ambulation. The Codated 1/7/14, note and yelled or holle to inability to exprended, "Resident I harm self or other inability to verbaliz cares by staff due potential for harm record lacked evidential for harm record lacked evidential for harm record lacked evidential for harm revised 11/7/14, naggression toward attempted but failed R15's care plan recovised 11/7/14, naggression toward Triggering factors member approach be able to decrease physical behaviors be able to avoid a towards staff and	mum Data Set (MDS) dated R15 had unclear speech and stood simple, direct om others. R15 had severely, with inattention and ing. The MDS identified R15 oral symptoms directed toward preatening, screaming or No physical behavioral entified. R15 was noted as ocomotion on the unit and sistance for transfers and dare Area Assessment (CAA) d R15 became angry/frustrated ared out for staff or at staff due less himself clearly. The CAA has not attempted to physically so Out of frustration, due to be needs, has physically refused to mis-communication. No to self or others." The medical dence of a comprehensive avioral patterns, rical triggers, baseline intensity and interventions	F	309	behavioral interventions.  E. Audit findings will be reported to Quality Assurance Committee for auditing.  F. Correction Date: 01/09/2015		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		E SURVEY MPLETED
		245125	B. WING _		12	/11/2014
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP O 227 MCKINLEY AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	R15 what was neer reinforcement of go praise; Documenting environment, staff doing cares, and; Langer in a positive "[R15] has difficulty self understood d/t Speech is garbled lead to social isolativists by volunteers activities, involving shared interests, pand providing him interest. Additional allowing extra time	ares, explaining and showing ded; Use of positive bod behaviors through verbaling triggers, such as the approach, exiting of visitors, or Use of redirection to diffuse way. The care plan also noted, a communicating and making [due to] impaired cognition. most of the time, which can ition." Interventions included informing him of upcoming him with others who had reviding one-to-one sessions with (unidentified) materials of interventions for R15 included for self-expression and es to ensure routine needs	F 30	09		
	12/11/14, revealed aggressive behavior attempts. R15's aggressing, running wiscreaming, shaking threats to kill other hangings and physmedical record lac behavior monitorin specific behaviors interventions.  Nursing notes on 1 R15 became very resident told them R15 took bag of cadresser drawer. St	tes dated 9/11/14, through repeated incidents of or with ineffective intervention gressive behaviors included neelchair into others, g his closed fist at staff, verbal s, hitting/kicking walls/wall ically assaulting staff. The ked evidence of systematic g to determine antecedents, or effectiveness of attempted 0/25/14, at 2:37 p.m. indicated angry when other [unidentified] to please stay out of their stuff, andy from other resident's aff were called into the room by became verbally aggressive				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMP	LETED
		245125	B. WING			12/1	1/2014
	PROVIDER OR SUPPLIER	3		2	TREET ADDRESS, CITY, STATE, ZIP CODE 27 MCKINLEY AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	R15 was swearing let [two residents] of 9/11/14, through review. The following provided in addition. On 10/5/14, R2 described verbal at toward others and behaviors placed Ephysical injury; sign resident care and social interactions; risk for injury; intruothers; and significal environment. Behaviore included redirection one-to-one time with is room. R15's be altered with implent interventions. On 1 documentation not verbally abusive with care and participated disrupted the living Daily Stand Up 12/8/14, through 12 concerns for each daily basis. The not or effectiveness of was no cumulative	taff.  1/21/14, at 3:29 p.m. indicated in hallway and didn't want to out of their bedroom.  Pring for R15 during the period 12/11/14, was requested for any documentation was in to the progress notes above: 15's behavior documentation and physical abuse directed rejection of care. The R15 at significant risk for inficantly interfered with participation in activities or placed others at significant ded on the privacy or activity of early disrupted care or living envior interventions attempted in, offering of food/fluids, the staff and returning R15 to chaviors were noted as easily mentation of these 2/6/14, the behavioral led R15 wandered and was hich significantly interfered with ion in social activities and a environment within the facility. D/Medicare Meeting notes from 2/11/14, indicated behavior resident were discussed on a stes lacked detail of behaviors attempted interventions. There is evaluation of antecedents, is behaviors or effectiveness of		309			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION ( BUILDING		(X3) DATE SURVEY COMPLETED	
		245125	B. WING		12	2/11/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 227 MCKINLEY AVENUE EVELETH, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	survey period on 1 p.m., on 12/9/14, f 12/10/14, from 7:0 12/11/14, from 8:0 wandered up and self-propelling in hobserved to be ph threatening but ca as a tall male with appearance.  During observation 12/8/14, at 5:40 p. room, self-propelli unable to make hifar side of one of to f limited space be was seated in her table. R15 persiste the narrow space, another resident's wheelchair. Sever the residents at the hold on, be patien the table so he wo maneuver to his propelli unable and a chair. With a loud volume oconfirmed R15 did get him to do som She reported staff telling them it wou with him and it wou with him and it would select the select them is	cobservations throughout the 2/8/14, from 1:00 p.m. to 8:00 rom 8:00 a.m. to 5:30 p.m., on 0 a.m. to 3:30 p.m. and on 0 a.m. to 5:00 p.m., R15 down the hallway, is wheelchair. R15 was not ysically aggressive or lled out loudly. R15 was noted broad shoulders and a strong in of the evening meal on m. R15 entered the dining ng his wheelchair. R15 was so way to his place setting at the he dining room tables because etween the table and R28, who wheelchair at the neighboring ed with self-propelling through repeatedly pushing into wheelchair with his own all staff in the area, along with the neighboring table told him to the and wait for the staff to move build have enough room to lace setting. R15 then becamed out and abruptly shoved the His speech was unintelligible, and gruff tone.  In 12/10/14, at 12:14 p.m. RN-A is hit staff if they were trying to ething he did not want to do. I reassured other residents by lid not last long, not to engage		309			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245125	B. WING		12	/11/2014	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 309	targeted another NA-H reported the tell other resident let the staff deal volume to be provided the tell other resident let the staff deal volume to be provided the staff deal volume to the staff	o say whether R15 would have resident when he got angry. e facility had instructed staff to s to just ignore/ avoid R15 and		309			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	) ` <i>'</i>			DATE SURVEY COMPLETED	
		245125	B. WING _		12/	11/2014	
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE  227 MCKINLEY AVENUE  EVELETH, MN 55734	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 309	of a stroke. She ad several training on these resources. T IDT sought contact was able to share sprovide a baseline. to share his likes a staff to be more proaddition, the admin consultant pharmaconsider medicatio assistance in manadministrator reportechniques were exof R15, including, "do not argue let he area do not treported the staff wattention, letting hir back, avoiding cert trigger inappropriat "goodbye."  The facility's undat who have Aggressi Behavior policy insprotected from abu	gnitive and behavioral effects ded facility staff had received these topics as a result of he administrator reported the with a family member who some of R15's social history to R15's spouse was also able and preferences, helping facility pactive, instead of reactive. In instrator reached out to the cist and nurse practitioner to a management options for agement of his behaviors. The ted behavior management when he is having behaviors, him be remove others from my to move him." She also were to provide him with the know they would be right that terminology found to the behavior, such as saying sive, Demanding and/or Difficult tructed all residents were to be use and staff were to be no with difficult, demanding and	F 30	9			

F5125025

Printed: 12/12/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245125

B. WING

12/10/2014

NAME OF PROVIDER OR SUPPLIER

FITZGERALD NH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

227 MCKINLEY AVENUE EVELETH. MN 55734

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 000 INITIAL COMMENTS K 000	
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.	
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.



Protecting, Maintaining and Improving the Health of Minnesotans

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

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COMP			SURVEY LETED	
		00588	B. WING		12/1	1/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
FITZGER	RALD NH AND REHAB	_	NLEY AVEN , MN 55734	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
****ATTENTION*****						
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall I with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the management of the schedule of the minnesota Department of the schedule of the minnesota Department of the schedule of	nether a violation has been				
	When a rule contain comply with any of the lack of compliance. re-inspection with a result in the assess	the several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	Department's staff, the following correct corrections are commake a copy of the original to the Minne	rS: n 12/11/14, surveyors of this visited the above provider and tion orders are issued. When hipleted, please sign and date, se orders and return the esota Department of Health, nice Monitoring, Licensing and				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 12/31/14

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
			5 14/10			
		00588	B. WING		12/1	1/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FITZGEF	RALD NH AND REHAB	_	NLEY AVEN			
		EVELETH	, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Certification Progra Suite 290, Duluth, M	m; 11 East Superior Street, IN 55802				
		tarted on 12/8/14, an as initiated on 12/9/14 through				
	Census: 22					
2 560	MN Rule 4658.0405 Plan of Care; Conte	Subp. 2 Comprehensive ents	2 560			1/9/15
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The com must include the inc	of plan of care. The of care must list measurable tables to meet the resident's of goals for medical, nursing, rechosocial needs that are opprehensive resident comprehensive plan of care dividual abuse prevention plan of a Statutes, section 626.557, agraph (b).				
	by:	ent is not met as evidenced on, interview and document		A. It is Facility practice to develop	a nlan	
	review, the facility famonitoring potential target behaviors of	ailed to develop a care plan for side effects, efficacy and/or medications for 2 of 6 reviewed for unnecessary		of care to include resident monitori side effects, efficacy, and/or target behaviors.  B. Facility wide audit completed to ensure that the resident plan of call	ng for o re	
	Findings include:			includes resident monitoring for sideffects, efficacy, and/or target behaves needed.		
	10/21/14, identified impairment. The MI	num Data Set (MDS) dated R2 had moderate cognitive DS indicated R2 had no m or depression; had no noses of dementia,		C. Resident R2 s plan of care har revised and updated to include interventions for monitoring for pot risks and side effects from Zyprexa and anti-coagulant use in the Medi	ential a, Paxil,	

Minnesota Department of Health

STATE FORM 2GXG11 If continuation sheet 2 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00588	B. WING		12/11	1/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
FITZGE	FITZGERALD NH AND REHAB 227 MCKINLEY AVENUE EVELETH, MN 55734						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 560	depression and cer and received antips anticoagulant medidays during the ass.  The signed Physici included paroxetine 20 milligrams (mg) (order started 5/1/1 mg at bedtime for a started 5/1/12); and every day for a diag 10/30/14).  R2 was periodically through 12/11/14, wholeeding, behaviors medication side efform the Psychotropic E 10/18/14, indicated depression, had a laa goal of not harmind directed staff monit were not customary read, attend activitic and verbal or physicidid not identify more effects or effectiver care plan did not id potential adverse cand antidepressant wer plan. The DON staff monitoring potential monitoring potential adversion and interesting potential adverse cand antidepressant wer plan. The DON staff monitoring potential monitoring potential monitoring potential adversion and interesting potential adverse cand antidepressant wer plan. The DON staff monitoring potential adversion and interesting potential adverse cand antidepressant wer plan. The DON staff monitoring potential adversion and interesting potential adverse cand antidepressant wer plan. The DON staff monitoring potential adversion and interesting potential adverse cand antidepressant wer plan. The DON staff monitoring potential adversion and interesting potential adverse cand antidepressant wer plan. The DON staff monitoring potential adverse cand antidepressant wer plan.	rebrovascular accident (CVA); sychotic, antidepressant and cation seven out of seven sessment period.  an Orders dated 11/26/14, et (commonly known as Paxil) once daily for depression 2); Zyprexa (antipsychotic) 5 dementia with delusions (order dispression dispression.  The care plan dispression dispression dispression dispression dispression dispression dispression. The care plan dispression dispression dispression dispression dispression. The care plan dispression dis	2 560	Administration Record. Resident plan of care has been revised and updated to include interventions for monitoring for potential risks and effects from hypnotic, antianxiety, antidepressant medication use in Medication Administration Record D. The plan of care for all curren residents have been reviewed for appropriate interventions and revisthat include monitoring for side efficacy, and/or target behaviors a added if necessary.  E. All Licensed Nursing Staff have educated on December 29, 2014 updating/revision of the resident pcare should a psychotropic mediciprescribed for a resident within the F. The Director of Nursing or dewill audit weekly for the proper carplanning of psychotropic drug use audit findings will be reported to C Assurance for ongoing monitoring G. Correction Date: 01/09/2015	d or side and the l. tt sions fects, and ve been on blan of ation be e facility. signee re e and Quality		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00588	B. WING		12/ <sup>-</sup>	11/2014	
	PROVIDER OR SUPPLIER	227 MCKI	DRESS, CITY, S	STATE, ZIP CODE			
FITZGEF	RALD NH AND REHAB		, MN 55734	<del>-</del> -			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 3	2 560				
	warfarin was done i INR (International N	n the progress notes when the lormalized Ratio, a blood test cation was working properly)					
	interventions or app	not address assessed needs, proaches related to hypnotic, anti-anxiety medications.					
	Minimum Data Set indicated R32 was	on 10/19/14. The admission (MDS) dated 10/28/14, cognitively intact and had hypertension, anxiety ssion.					
	(CAA) dated 10/28/	rug care area assessment 14 indicated R32's was unable d was taking antianxiety, d sedative/hypnotic					
	electronic health red (hypnotic medication for insomnia at bed 20 mg by mouth at	dication orders current in the cord indicated Ambien n) 5 milligrams (mg) by mouth time; Celexa (antidepressant) bedtime; and Ativan tion) 0.5mg by mouth for					
	R32 was taking all tinterventions and m	red on 12/11/14, stated verified three medications and the nonitoring for insomnia, ciety should be on the care					
	dated 5/8/13, identification were developed and assessment and income assessment and inc	rehensive Care Plans policy fied comprehensive care plans d revised based on resident cluded services that were to in or maintain the resident's					

Minnesota Department of Health

STATE FORM 2GXG11 If continuation sheet 4 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00588	B. WING 12		12/1	1/2014		
NAME OF PROVIDER OR SUPPLIER  STREET ADDR  EITZGERALD NH AND REHAB  227 MCKIN				DRESS, CITY, STATE, ZIP CODE  NLEY AVENUE  I, MN 55734				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
2 560	highest practicable psychosocial well-b R32's care plan did interventions or appantidepressant and R32 was admitted of Minimum Data Set indicated R32 was diagnoses including disorder and depression and depression and antidepressant, and medications.  R32's physician medications health reflectronic health reflectronic health reflectronic medications.  R32's physician medications health reflectronic health reflectronic health reflectronic medication for insomnia at bed 20 mg by mouth at (antianxiety medica anxiety once a day.  The DON, interview R32 was taking all finiterventions and medications and m	physical, mental and eing.  not address assessed needs, proaches related to hypnotic, anti-anxiety medications.  on 10/19/14. The admission (MDS) dated 10/28/14, cognitively intact and had g hypertension, anxiety ssion.  rug care area assessment 14 indicated R32's was unable d was taking antianxiety, d sedative/hypnotic  dication orders current in the cord indicated Ambien (m) 5 milligrams (mg) by mouth time; Celexa (antidepressant) bedtime; and Ativan tion) 0.5mg by mouth for  yed on 12/11/14, stated verified three medications and the nonitoring for insomnia, kiety should be on the care  rehensive Care Plans policy fied comprehensive care plans d revised based on resident cluded services that were to in or maintain the resident's physical, mental and						

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00588	B. WING		12/1	1/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S <b>NLEY AVEN</b>	STATE, ZIP CODE		
FITZGER	ALD NH AND REHAE	{	, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 5	2 560			
2 830	The Director of Nur develop, review, an procedures to ensur plans on all residen The Director of Nur educate all appropriocedures. The Director of Nur develop monitoring compliance.  TIME PERIOD FOR (21) days.	THOD OF CORRECTION: sing or designee could d/or revise policies and the development of care its. sing or designee could that staff on the policies and the sing or designee could systems to ensure ongoing R CORRECTION: Twenty-one	2 830			1/9/15
2 000	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in This MN Requirements.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	2 000			179/13
		on, interview and document		A. It is Facility practice to seek of	outside	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
			A. BOILDING.			
		00588	B. WING		12/11	1/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FITZGEF	RALD NH AND REHAE	₹	NLEY AVEN , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
	review, the facility fassess, identify, im behavioral interven who demonstrated aggressive behavioral include:  R15's nurse Practice 9/10/14, identified of depression, aphasi left-middle cerebral accident (CVA/ stronote indicated, R15 be controlled at this recent aggressive to other residents H	ailed to comprehensively plement and monitor effective tions for 1 of 1 resident (R15) verbally and physically ors directed toward others.  Oner (NP)-A note dated diagnoses including a and history of a large, artery Cerebrovascular ske) in 9/13. The progress is "Depression appears to a point and he has not had any behaviors towards staff or e is currently on citalopram pressant medication] and this		behavioral consulting services for residents displaying behavioral consulting services. B. Referral for resident R15 has made for outside consulting service. C. Resident R15 has an updated aggressive behavior monitoring prin place.  D. Facility wide audit for all residence completed to review behavioral neif appropriate behavioral monitoring interventions implemented.  E. The Director of Social Services review behavioral notes and concewithin 24-72 hours.  F. The Director of Social Services designee will audit weekly to ensure the proper follow-up regarding behavioral concerns and use of behavioral consulting services as behavioral concerns and the use of behavioral consulting services as	been ces. I rogram ents eeds and ng es will erns es or ire that navioral onsulting ator will	
	10/8/14, identified I sometimes underst communication from impaired cognition, disorganized thinking with verbal behavior others, including the cursing at others. In symptoms were idented independent with low required limited assumbulation. The Cataland yelled or holler to inability to express noted, "Resident has	num Data Set (MDS) dated R15 had unclear speech and good simple, direct mothers. R15 had severely with inattention and ng. The MDS identified R15 ral symptoms directed toward reatening, screaming or lo physical behavioral entified. R15 was noted as accomotion on the unit and distance for transfers and lare Area Assessment (CAA) I R15 became angry/frustrated led out for staff or at staff due as not attempted to physically. Out of frustration, due to		necessary. G. Correction Date: 01/09/2015		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAIN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COIVIE	LEIED
		00588	B. WING		12/1	1/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FITZGEF	RALD NH AND REHAE	4	NLEY AVEN , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	inability to verbalize cares by staff due to potential for harm to record lacked evide evaluation of behave antecedents/historic frequency, baseline attempted but failed.  R15's care plan revervised 11/7/14, not aggression towards. Triggering factors is member approach, be able to decrease physical behaviors be able to avoid a ptowards staff and reincluded the following approach during care included the following proach during care in a positive in reinforcement of go praise; Documenting environment, staff adoing cares, and; U anger in a positive in lead to social isolativistic by volunteers, activities, involving shared interests, prand providing him interest. Additional allowing extra time periodic approache were met.	e needs, has physically refused o mis-communication. No o self or others." The medical ence of a comprehensive vioral patterns, cal triggers, baseline e intensity and interventions	2 830			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  227 MCKINLEY AVENUE EVELETH, MN 55734   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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				A. BUILDING:			
FITZGERALD NH AND REHAB  227 MCKINLEY AVENUE EVELETH, MN 55734  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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  (X5) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTI			00588	B. WING		12 <i>/</i>	11/2014
Cach Deficiency Must be preceded by Full Regulatory or Lsc Identifying Information   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   Deficiency   PREFIX TAG   PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   COMPLE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DATE)   CROSS-REFERENCED TO THE APPROPRIATE DATE (CROSS-REFERENCED TO THE APPROPRIATE DATE (CROSS-REFERENC	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  2 830  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  2 830	FITZGE	RALD NH AND REHAE	3				
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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
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	12/11/14, revealed aggressive behavior attempts. R15's ag cursing, running wh screaming, shaking threats to kill others hangings and phys medical record lack behavior monitoring specific behaviors interventions.  Nursing notes on 1 R15 became very a resident told them R15 took bag of cad dresser drawer. Stacall light and R15 b with resident and s  Nursing notes on 1 R15 was swearing let [two residents] of 9/11/14, through review. The following provided in addition On 10/5/14, R1 described verbal artoward others and behaviors placed R physical injury; sign resident care and social interactions; risk for injury; intruction of the significant care and social interactions; risk for injury; intruction of the significant care and social interactions; risk for injury; intruction of the significant care and social interactions; risk for injury; intruction of the significant care and social interactions; risk for injury; intruction of the significant care and social interactions.	repeated incidents of or with ineffective intervention gressive behaviors included heelchair into others, g his closed fist at staff, verbals, hitting/kicking walls/wall ically assaulting staff. The ked evidence of systematic g to determine antecedents, or effectiveness of attempted of the please stay out of their stuff. Indy from other [unidentified] to please stay out of their stuff. Indy from other resident's aff were called into the room by became verbally aggressive taff.  1/21/14, at 3:29 p.m. indicated in hallway and didn't want to out of their bedroom.  In the progress notes above: 15's behavior documentation was a to the progress notes above: 15's behavior documentation and physical abuse directed rejection of care. The care at significant risk for inficantly interfered with participation in activities or placed others at significant ded on the privacy or activity of antly disrupted care or living vior interventions attempted an offering of food/fluids,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00588	B. WING		12/1	1/2014
	PROVIDER OR SUPPLIER	227 MCKI	DRESS, CITY, S NLEY AVENU I, MN 55734	ITATE, ZIP CODE <b>JE</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	his room. R15's bel altered with implem interventions. On 12 documentation note verbally abusive who care and participatidisrupted the living.  Daily Stand Up. 12/8/14, through 12 concerns for each redaily basis. The note or effectiveness of was no cumulative description of R15's attempted intervent survey period on 12 p.m., on 12/9/14, from 12/10/14, from 7:00 12/11/14, from 8:00 wandered up and diself-propelling in his	naviors were noted as easily tentation of these 2/6/14, the behavioral ed R15 wandered and was nich significantly interfered with on in social activities and environment within the facility. Medicare Meeting notes from 2/11/14, indicated behavior resident were discussed on a reselacked detail of behaviors attempted interventions. There evaluation of antecedents, a behaviors or effectiveness of cions.  Observations throughout the 2/8/14, from 1:00 p.m. to 8:00 om 8:00 a.m. to 5:30 p.m., on a.m. to 3:30 p.m. and on a.m. to 5:00 p.m., R15	2 830			
		ed out loudly. R15 was noted proad shoulders and a strong				
	12/8/14, at 5:40 p.n room, self-propellin unable to make his far side of one of the of limited space between was seated in her vitable. R15 persisted the narrow space, ranother resident's vitable.	of the evening meal on n. R15 entered the dining g his wheelchair. R15 was way to his place setting at the edining room tables because tween the table and R28, who wheelchair at the neighboring d with self-propelling through epeatedly pushing into wheelchair with his own I staff in the area, along with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00588	B. WING		12/	11/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FITZGFF	RALD NH AND REHAB	_	INLEY AVENU	JE		
	THE WITH THE RELIAB	EVELETI	H, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	hold on, be patient at the table so he would maneuver to his plat visibly upset, yelled table and a chair. He with a loud volume  During interview on confirmed R15 did leget him to do some She reported staff received the telling them it would with him and it would be upset to stargeted another received the work of the telling them it would be upset to stargeted another received the work of the telling them it would be upset to stargeted another received the work of the telling them it would be upset to be upset to have the telling them it would be upset to be upset to have the telling them it would be upset to be upset to have the telling them it would be upset to be upset to have the telling them it would be upset to be upset to have the telling them it would be upset to be upset to have the telling them it would be upset to be upset	12/10/14, at 12:14 p.m. RN-A hit staff if they were trying to thing he did not want to do. eassured other residents by I not last long, not to engage				
	tell other residents in let the staff deal with let	to just ignore/ avoid R15 and h him.  12/11/14, at 10:34 a.m. social (ED) denied knowledge of R15 by aggressing toward other cated R15's interdisciplinary working on developing liress R15's behaviors. SSD current behavior interventions ing: ensuring his needs were offering him coffee, informal				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  12/11/2014  STREET ADDRESS, CITY, STATE, ZIP CODE  227 MCKINLEY AVENUE EVELETH, MN 55734  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  227 MCKINLEY AVENUE EVELETH, MN 55734  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				A. BUILDING:			
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DEFICIENCY)		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
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 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	stated, "He does not for immediate gratin Trying to communic SSD reported she is service role for approach."  During interview ab address R15's behap.m. the stated they that typically provid similar to R15, seel educated their staff behavior triggers at to the behaviors. The research on the coof a stroke. She ad several training on these resources. The sought contact was able to share as provide a baseline, to share his likes at staff to be more proposed addition, the adminiconsultant pharmac consider medication assistance in mana administrator reportechniques were exported the staff wattention, letting hir back, avoiding cert trigger inappropriat "goodbye."	ot seem to understand inability fication of what he wants cate his needs is a trigger." had only been in the social proximately one and one-half or out facility interventions to aviors on 12/11/14, at 2:44 by consulted with another facility led services for individuals king ideas for how they fin recognizing and identifying and age appropriate responses he IDT also conducted some gnitive and behavioral effects led facility staff had received these topics as a result of he administrator reported the with a family member who some of R15's social history to R15's spouse was also able and preferences, helping facility pactive, instead of reactive. In istrator reached out to the cist and nurse practitioner to a management options for agement of his behaviors. The sted behavior management expected of staff in their support When he is having behaviors, him be remove others from the type of the provide him with men know they would be right ain terminology found to the behavior, such as saying				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00588	B. WING		12/1	1/2014
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	who have Aggressis Behavior policy inst protected from abuse educated on dealing aggressive behaviors. Suggested methods The director of nurse and revise policies developement and behavioral intervent education related to system could be init. Time period for confidence of MN St. Statute 144. Prevention And Confidence of the confidenc	ve, Demanding and/or Difficult ructed all residents were to be se and staff were to be g with difficult, demanding and r.  s of correction: sing or designee could review and procedures related to the implementation of effective tions. Staff could be provided to the policies and a monitoring tiated to ensure compliance.  rection: Twenty one (21) days.  A.04 Subd. 3 Tuberculosis and a monitoring tiated to ensure stablish and the provider must establish and the provider must e	2 830			1/9/15

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Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00588	B. WING		12/1	1/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
FITZGER	ALD NH AND REHAE	}	NLEY AVEN , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 13	21426			
	by: Based on interview facility failed to ensiste tuberculin skin employees (NA-B,N failed to ensure residays of admissions failed to ensure that for 1 of 5 residents  Findings include:  The undated MANT SCREENING/DIAG indicated all first timfor infection with tulof admisstion. Skin step procedure. As (7-21 days) weeks recieve a two-step reviesed TB Policy resident will be screesed the two-step reviesed that will be screened test will b	and document review the ure employees received the 2 test (TST) for 3 of 5 NA-B,NA-D) reviewed and idents received a TST within 3 1 of 5 resident (R30) and t a 2nd TST was completed (R19) reviewed.  TOUX (TST)/TUBERCULOSIS NOSED TUBERCULOSIS, he residents will be screened become test will be give 1-3 later. New employees will TST when they start. A updated 12/3/14 indicated all eened within 72 hours and a given 2 weeks later. eve there test upon start of  10/2/14. NA-B received his 1, a second TST was not given will a received her first 2nd TST was not given until		A. It is the policy of this facility to complete timely 2-step tuberculin testing and screening on all employed and admitted residents. Resident has expired 12/21/2014. A copy of previous tuberculin skin test documentation was obtained and in the resident file and TB tracking Resident R30 s 1st tuberculin skin was completed 12/19/2014 and the step was completed 12/30/2014, adocumentation was obtained and in the resident file and TB tracking B. The facility s policy and proceed has been reviewed.  C. Files of all employees and restor 2014 have been audited to ensure 2-step tuberculin skin testing documentation and annual assess are complete and placed in person resident chart, and TB tracking bir D. Audits of all newly hired and nadmitted residents will be complete assure that 2-step tuberculin testing documentation is complete and file employee s personnel file and reschart and TB tracking binder. To ethe timeliness of tuberculin skin teand annual assessment, results of audits will be reviewed weekly at management meetings and quarted during Quality Assurance meeting accuracy, timeliness, and/or any for any file and couracy, timeliness, and/or any file and couracy.	pyees R19	

STATE FORM 6899 If continuation sheet 14 of 18 2GXG11

	IT OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED		
		00588	B. WING		12/1	1/2014
					12/1	1/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S NLEY AVEN	STATE, ZIP CODE		
FITZGER	ALD NH AND REHAB	_	, MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 14	21426			
	indicating a 2nd TS	T was completed.		action.		
	R30 did not recieve	o the facility on 8/19/2014. her first TST until 9/29/14.		E. The Director of Nursing or her designee will be responsible for completion and timeliness of 2-ste tuberculin skin testing and annual		
	R30 recieved his fir	to the facility on 10/1/2014, st TST on 10/15/15, there is ndicating a 2nd TST was		assessments for employees and residents.  F. Correction date: December 29, 2014		
	registered nurse (R received the TST w R19's medical reco	on 12/10/14, at 12:10 p.m. N)-A stated R30 had not vithin 72 hours of admission. rd lacked documentation that appleted. RN-A verified the				
	the director of nursi TST's were not cor	0 p.m. during an interview with ng (DON) who verified that the mpleted for residents R30 and as NA-B, NA-C, NA-D.				
	The administrator of assessment process to be sure they have	THOD OF CORRECTION: or designee could review the set for residents and employees the two-step tuberculin test hinistrator or designee could nce.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21880	MN St. Statute 144. Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			1/9/15
	shall be encouraged	nces. Patients and residents d and assisted, throughout y or their course of treatment,				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D WING			
		00588	B. WING		12/1	1/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FITZGEF	RALD NH AND REHAE	₹	NLEY AVEN , MN 55734	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	to understand and patients, residents, residents, residents, residents, residents, residents, residents may voice changes in policies and others of their interference, coerci including threat of orievance procedur well as addresses a Office of Health Fanursing home ombound Americans Act, see posted in a conspication of the provides outpatient have a written interest a minimum, sets followed; specifies limits for facility resor resident to have advocate; requires grievances; and proan impartial decision otherwise resolved residential programs 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed	exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older tion 307(a)(12) shall be	21880			

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPL	
		00588	B. WING		12/1	1/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FITZGE	RALD NH AND REHAE	3	NLEY AVEN , MN 55734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21880	Continued From pa	nge 16	21880			
	by: Based on interview facility failed to act of 1 resident (R13) his roommate's bet room assignment.  Findings include: R13, interviewed or "The administration roommate] sometin others." R13 stated somewhat threaten this way, I don't trust the nursing assistance felt, but he had nor administration.  R13's admission M 11/17/14, identified impairment.  R13's Resident Prolicensed practical nof:36 p.m. noted, "Wanother res [resider want to go in his roomes [resident's] behrm [television room completed for R13's Upon review of R13's Upon review of R13's Upon review of R13's Upon review of R13's Interview of R13's Upon review o	and document review, the on resident complaints, for 1 who expressed complaints of navior and requested a new in 12/8/14, at 4:48 p.m., stated, in could stand to watch [his mes and see how he treats if the roommate appeared ing and added, "Let me put it st him" R13 stated some of ints (NAs) were aware of how mot reported it to licensed staff inimum Data Set (MDS) dated moderate cognitive or see (LPN)-F dated 12/5/14, at vants to switch rooms due to int's] behaviors, [R13] did not om after supper due to other aviors, he went [and] sat in TV instead." No follow-up was see request for a room change.  12/11/14, at 10:34 a.m. social SD) confirmed she handled all age requests. SSD denied is request to change rooms. 3's 12/5/14, progress note SSD should have forwarded the		A. It is the Facility practice to acknowledge and act on resident/concerns.  B. The facility 's grievance/concerns are policy has been revised and review appropriateness.  C. All staff members will be educe about revision of the policy and the chain of communication regarding registering a resident/family members oncern. All concerns will be given Administrator.  D. Resident R13 was offered a rechange and has since moved roose. Follow-up audits of resident/faconcerns will be completed daily for weeks, then weekly for one month Director of Social Services. The reconcerns will be determined by the Assurance Committee.  F. Correction Date: December 3	cern wed for cated e proper ber en to the com ms. amily for two n by the need for mily e Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00588	B. WING		12/1	1/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	RESS, 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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON SHOULD BE COMPLETE E APPROPRIATE DATE		
21880	request to her for for The director of nurs 12/11/14, at 2:28 p. process to address report "up the chair that a resident's red as complaints of as should be addressed was not informed or room mate or requesting the facility's undate noted residents and were encouraged to presenting complainthemselves or othe care.  SUGGESTED MET The Director of Nurreview and revise president grievances policies and perform resident grievance facility.		21880				