#### DEPARTMENT

DEPARTMENT OF HEALTH AND HUMA MEDIC	AN SERVICES ARE/MEDICAID CERTIFICATION		DICARE & MEDICAID SERVICES  ID: 40YO			
	- TO BE COMPLETED BY THE STA		Facility ID: 00298			
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245368 2.STATE VENDOR OR MEDICAID NO. (L2) 304340100	3. NAME AND ADDRESS OF FACILITY (L3) GRAND VILLAGE (L4) 923 HALE LAKE POINTE (L5) GRAND RAPIDS, MN	(L6) 55744	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other  8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  12/31			
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 119 (L18)  13.Total Certified Beds 119 (L17)	10.THE FACILITY IS CERTIFIED AS:  X A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC  B. Not in Compliance with Program Requirements and/or Applied Waivers	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director			
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS				
18 SNF 18/19 SNF 19 SNF 119 (L37) (L38) (L39)	ICF IID (L42) (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)			
16. STATE SURVEY AGENCY REMARKS (IF APPLIC						
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:			
Jana Bromenshenkel, HFE NEII	01/10/2016 (L19)	Mark Meath	Enforcement Specialist 01/13/2016 (L20)			
PART II - TO BE	COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE S	TATE AGENCY			
19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate  2. Facility is not Eligible	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)			

2. Facility is not Eligibl	(L21)			_
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 11/01/1986	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY  05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS	5	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
(L27)	<ul><li>A. Suspension of Admissions:</li><li>B. Rescind Suspension Date:</li></ul>	(L44)	04-Other Reason for Williaman	07-Provider Status Change 00-Active
		(L45)		
28. TERMINATION DATE:	29. INTERMEDIA	ARY/CARRIER NO.	30. REMARKS	
	03001			
	(L28)	(L3		
31. RO RECEIPT OF CMS-1539	32. DETERMINAT	TION OF APPROVAL DATE		
	12/11/2015 (L32)	(L3:	DETERMINATION APPROVAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245368

January 13, 2016

Mr. Kyle Hedlund, Administrator Grand Village 923 Hale Lake Pointe Grand Rapids, Minnesota 55744

Dear Mr. Hedlund:

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 December 16, 2015 the above facility is certified for:

119 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 119 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 letter.

Sincerely,

Mark Meeth

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

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 10, 2016

Mr. Kyle Hedlund, Administrator Grand Village 923 Hale Lake Pointe Grand Rapids, Minnesota 55744

RE: Project Number S5368026

Dear Mr. Hedlund:

On November 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2015, effective December 16, 2015 and therefore remedies outlined in our letter to you dated November 20, 2015, 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 Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

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

#### **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 245368	entification Number A. Building		(Y3) Date of Revisit 12/30/2015
Name of Facility		Street Address, City, State, Zip Code	
GRAND VILLAGE		923 HALE LAKE POINTE GRAND BAPIDS, MN 55744	

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			rrection				Correction					Correction
ID Prefix	F0225		mpleted /15/2015	ID Prefix	F0226		Completed <b>12/15/2015</b>		ID Prefix	F0278		Completed <b>12/15/2015</b>
Reg. # LSC	483.13(c)(1)(ii)	)-(iii), (c)(2) -		Reg. # LSC	483.13(c)				Reg. # LSC	483.20(g) -	(i)	
		Co	orrection				Correction					Correction
ID Prefix	F0279	Co	mpleted /15/2015	ID Prefix	F0280		Completed 12/15/2015		ID Prefix	F0281		Completed <b>12/15/2015</b>
Reg. # LSC	483.20(d), 483	.20(k)(1)		Reg. # LSC	483.20(d)(3),	483.10(k)(2	2)		Reg. # LSC	483.20(k)(3	3)(i)	
			orrection				Correction					Correction
ID Prefix	F0282		mpleted /15/2015	ID Prefix	F0309		Completed <b>12/15/2015</b>		ID Prefix	F0311		Completed <b>12/15/2015</b>
Reg. # LSC	483.20(k)(3)(ii)	)		Reg. # LSC	483.25				Reg. # LSC	483.25(a)(2	2)	
		Co	orrection				Correction					Correction
ID Prefix	F0312		mpleted /15/2015	ID Prefix	F0318		Completed 12/15/2015		ID Prefix	F0323		Completed <b>12/15/2015</b>
Reg. # LSC	483.25(a)(3)			Reg. # LSC	483.25(e)(2)				Reg. # LSC	483.25(h)		
ID Prefix	F0325	Co	orrection ompleted /15/2015	ID Prefix	F0329		Correction Completed 12/15/2015		ID Prefix	F0371		Correction Completed 12/15/2015
	483.25(i)		7 10/2010		483.25(I)		12/10/2010			483.35(i)		12/10/2010
Reviewed		Reviewed By	y	Date:		ure of Sur	•				Date:	
State Agen		LB/mm		01/10/20			32601					30/2015
Reviewed CMS RO	ву — Г	Reviewed By	y 	Date:	Signat	ure of Sur	veyor:				Date:	

#### **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 245368	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/30/2015
Name	e of Facility		Street Address, City, State, Zip Code	
GF	RAND VILLAGE		923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	

(Y4) Item		(Y5) Date	(Y4) Item	(	(Y5) Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
ID Prefix	E0428	Completed <b>12/15/2015</b>	ID Prefix	E0//21	Completed <b>12/15/2015</b>	l :	ID Prefix	E0441		Completed <b>12/15/201</b> 5
		12/15/2015			12/15/2013	'				12/15/2015
Reg. # LSC	483.60(c)		Reg. #	483.60(b), (d), (e)			Reg. # LSC	483.65		
		Correction								
		Completed								
ID Prefix	F0465	12/15/2015								
	483.70(h)									
LSC										
Reviewed I	Ву	Reviewed By	Date:	Signature of	Survevor:				Date	:
State Agen		LB/mm	01/10/20	-	3260	1				/30/2015
Reviewed I		Reviewed By	Date:	Signature of					Date	
CMS RO		· <b>,</b>		3						
	to Survey Com	pleted on:		Check for any U	ncorrected Det	icienc	ies Was a	Summary	of	
	11/6/2			Uncorrected D	eficiencies (C	MS-25	67) Sent to	the Facilit	y? YES	NO

#### **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 245368	(Y2) Multiple Construct  A. Building  B. Wing  01 -	on MAIN BUILDING 01	(Y3) Date of Revisit 12/16/2015
Name of Facility		Street Address, City, State, Zip Code	
GRAND VILLAGE		923 HALE LAKE POINTE	
		GRAND BAPIDS MN 55744	

(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		Correction Completed 12/16/2019	d			Correction Completed 12/16/2015		ID Prefix			Correction Completed 12/16/2015
	NFPA 101			NFPA 101				Reg. #	NFPA 101		
LSC	K0022		LSC	K0050				LSC	K0056		
		Correction				Correction					Correction
		Completed	t t			Completed					Completed
Reg. # LSC			Reg. # LSC					Reg. # LSC			
		Correction				Correction					Correction
		Completed	t l			Completed					Completed
			ID Prefix					ID Prefix			<u></u>
Reg. #			Reg. #					Reg. #			
			LSC					LSC			
		Correction				Correction					Correction
ID Prefix		Completed	JD Prefix			Completed		ID Profix			Completed
											<u></u>
Reg. # LSC			Reg. #					Reg. # LSC			<u> </u>
		Correction				Correction					Correction
ID D ('		Completed	d			Completed		ID D "			Completed
Reg. # LSC			Reg. # LSC					Reg. # LSC			<u> </u>
Reviewed I	By Re	eviewed By	Date:	Signatu	re of Sur	veyor:				Date:	
State Agen	cy 7	TL/mm	01/10/20	16		27200				12/	16/2015
Reviewed I	Ву — Ке	eviewed By	Date:	Signatu	re of Sur	veyor:				Date:	
CMS RO											
Followup t	to Survey Comp								Summary o		
	11/4/20	15		Uncorrec	ted Defic	iencies (CN	15-256	o/) Sent to	the Facility	YES	NO

#### **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 245368	(Y2) Multiple Con A. Building B. Wing	B ACUTE	(Y3) Date of Revisit 12/16/2015
Name	of Facility		Street Address, City, State, Zip Code	
GF	AND VILLAGE		923 HALE LAKE POINTE	
			GRAND RAPIDS MN 55744	

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 12/16/2015	ID Prefix		Correction Completed		ID Prefix		Correction Completed
	NFPA 101						<b>.</b>		
LSC	K0050		LSC				LSC _		
		Correction			Correction				Correction
ID Profix		Completed	ID Profix		Completed		ID Profix		Completed
Reg. # LSC			Reg. #				Reg. # LSC		
		Correction			Correction				Correction
ID Profix		Completed	ID Profix		Completed		ID Profix		Completed
							ъ "		
Reg. # LSC			Reg. #				Reg. # _ LSC _		<u> </u>
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #					•				
LSC							LSC		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #									
			LSC				LSC		
Reviewed I	Ву R	eviewed By	Date:	Signature of Sur	veyor:			Date	:
State Agen	cy	ΓL/mm	01/10/2016		27200			12/	16/2015
Reviewed I	By R	eviewed By	Date:	Signature of Sur	veyor:			Date	:
CMS RO									
Followup 1	to Survey Comp			Check for any Uncor Uncorrected Defice				ha Faailiu.O	
	11/4/20	115		Shoomedied Delic	iciicies (CII	.0-200	,, Jeni io i	ne racility? YES	NO



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 10, 2016

Mr. Kyle Hedlund, Administrator Grand Village 923 Hale Lake Pointe Grand Rapids, Minnesota 55744

Re: Reinspection Results - Project Number S5368026

Dear Mr. Hedlund:

On December 30, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2015, with orders received by you on November 24, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

#### Mark Meath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

		State Form: Revi	sit Report	
(Y1)	Provider / Supplier / CLIA / Identification Number 00298	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/30/2015
Name	e of Facility		Street Address, City, State, Zip Code	
GF	RAND VILLAGE		923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item	(Y5	) Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
ID Duefin	00500	Completed	ID Deafise	00505	Completed		ID Duefic	00570		Completed
ID Prefix		12/15/2015	ID Prefix		12/15/2015		ID Prefix	-		12/15/2015
Reg. # LSC	MN Rule 4658.	0405 Subp.	Reg. # LSC	MN Rule 4658.0405 Sเ	ibp. : - -		Reg. # LSC	MN Rule 46	58.0405	Subp.
		Correction			Correction					Correction
ID Prefix	20830	Completed <b>12/15/2015</b>	ID Prefix	20805	Completed 12/15/2015		ID Profix	20915		Completed 12/15/2015
	-				<del>_</del>					<del></del>
	MN Rule 4658.			MN Rule 4658.0525 Sเ	ibp. ; 	,		MN Rule 46		Subp.   
		Correction			Correction					Correction
ID Prefix	20920	Completed <b>12/15/2015</b>	ID Prefix	20965	Completed 12/15/2015		ID Prefix	21025		Completed 12/15/2015
	MN Rule 4658.	0525 Subp.		MN Rule 4658.0600 Sเ				MN Rule 46		<u> </u>
		Correction			Correction					Correction
ID Prefix	21390	Completed <b>12/15/2015</b>	ID Prefix	21426	Completed 12/15/2015		ID Prefix	21530		Completed <b>12/15/2015</b>
Reg. # LSC	MN Rule 4658.	0800 Subp.	Reg. # LSC	MN St. Statute 144A.0	4 Su∣			MN Rule 46		<u>A.B</u> .C
		Correction			Correction					Correction
ID Prefix	21540	Completed <b>12/15/2015</b>	ID Prefix	21620	Completed 12/15/2015		ID Prefix	21685		Completed 12/15/2015
	-			MN Rule 4658.1345				MN Rule 46	E0 1/1E	
LSC	MN Rule 4658.			WIN Rule 4000.1340	<del>-</del>			MIN Rule 40		
Reviewed E	ByF	Reviewed By	Date:	Signature of Su	ırveyor:				Date:	
State Agen	су	LB/mm	01/10/20	16	326	01			12/	30/2015
Reviewed E		Reviewed By	Date:	Signature of Su					Date:	

Event ID: 40YO12

	State Form: Revisit Report							
(Y1)	Provider / Supplier / CLIA / Identification Number 00298	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/30/2015				
Name of Facility			Street Address, City, State, Zip Code					
GF	RAND VILLAGE		923 HALE LAKE POINTE GRAND RAPIDS, MN 55744					

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5) Date
		Correction					
ID D .	04005	Completed					
ID Prefix		12/15/2015					
	MN St. Statute 626.557	Sul					
LSC			_				
Reviewed	By Reviewed	Ву	Date:	Signature of Surve	eyor:		Date:
State Agen			01/10/2016		326	501	12/30/2015
Reviewed	-,		Date:	Signature of Surve	evor:		Date:
CMS RO	-, Iteriowea	-,	24.0.	Jigilataro di Garve	.,		24.01
	to Survey Completed or	<u>.</u>		Nhook for one Uncer	atad D-	ficiencies Was a Commi	
. Silowup	11/6/2015	•		neck for any uncorre Uncorrected Deficie	ected De encies (C	ficiencies. Was a Sumn MS-2567) Sent to the Fa	nary of acility? YES NO
	RM: REVISIT REPORT (5	(00)		Page 2 of 2	• • •		nt ID: 40YO12

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 40YO

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	I	Facility ID: 00298
MEDICARE/MEDICAID PROVIDER N     (L1) 245368  2.STATE VENDOR OR MEDICAID NO.     (L2) 304340100	0.	3. NAME AND ADD (L3) GRAND VILL (L4) 923 HALE L4 (L5) GRAND RAF	LAGE AKE POINTE	ГҮ	(	L6) <b>55744</b>	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 6. DATE OF SURVEY 11/06		7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dual	PLIER CATEGOR 05 HHA 06 PRTF	Y 09 ESRD 10 NF	13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 11/06/ 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	Œ	FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12. Total Facility Beds  13. Total Certified Beds	119 (L18) 119 (L17)	X B. Not in Comp	ce With quirements Based On: cceptable POC		2. 3. 4.	pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements:  6. Scope of Servi 7. Medical Direc 8. Patient Room 3 9. Beds/Room  (L12)	tor
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  119  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILIT	Y MEETS	(L15)	
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE Date :					18. STATE S	SURVEY AGENCY API	PROVAL Weath	Date:
Yvonne Switajewski, l	HFE NEII	1	12/04/2015	(L19)	Enforcement Specialist 12/10/2015 (L20)			
	PART II - TO	BE COMPLETEI	D BY HCFA RI	EGIONAL	OFFICE O	OR SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above:			
22. ORIGINAL DATE  OF PARTICIPATION  11/01/1986  (L24)	23. LTC AGREEMI BEGINNING I		4. LTC AGREEME ENDING DATE (L25)		VOLUNTAF 01-Merger, C 02-Dissatisfa	Closure action W/ Reimbursemen		L30)  FARY  eet Health/Safety  eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L44) (L45)			voluntary Termination ason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	KS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DA	ГЕ				
	(L32)			(L33)	DETERM	INATION APPRO	VAL	



Electronically delivered November 20, 2015

Ms. Susan Johnson, Administrator Grand Village 923 Hale Lake Pointe Grand Rapids, Minnesota 55744

RE: Project Number S5368026

Dear Ms. Johnson:

On November 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

<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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

#### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 16, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 16, 2015 the following remedy will be imposed:

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

#### 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.

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.

Grand Village November 20, 2015 Page 4

#### 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 February 6, 2016 (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

Grand Village November 20, 2015 Page 5

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 May 6, 2016 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525 Grand Village November 20, 2015 Page 6

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

Sincerely,

Mark Meath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/04/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11	/06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT		F 0	00		
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are cour signature is not required irist page of the CMS-2567 nic submission of the POC will cion of compliance.				
F 225 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF	PORT	F 2	25		12/15/15
	been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for	at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry				
	involving mistreatm including injuries of misappropriation of immediately to the ato other officials in a through established State survey and complete the state of the state	<b>3</b> ,				
ABORATOR'	PRINTER OF PROVIDER	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE

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

(X6) DATE

**Electronically Signed** 12/01/2015

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245368	B. WING		11/06/2015		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744				
(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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	violations are thoro prevent further pote investigation is in p  The results of all in to the administrator representative and with State law (inclucertification agency incident, and if the	eve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225				
	by: Based on interview facility failed to immagency and thoroug possible mistreatm misconduct for 1 of and for 1 of 2 resid involved with potential possible mistreatm misconduct for 1 of and for 1 of 2 resid involved with potential possible misconduct.  R148's quarterly M 9/25/15, indicated for an indicated for	NT is not met as evidenced and document review, the nediately report to the State ghly investigate incidences of ent related potential sexual 3 incident reports reviewed ents (R148, R145) who were tial sexual misconduct.  Inimum Data Set (MDS) dated R148 was diagnosed with lisorder, depression and the MDS also indicated R148 re impairment, required activities of daily living and diassistance of one staff while DS also indicated R148 reggression towards other 1-3		Corrective Action- OHFC has been notified of the potential sexual misc of residents 148 and 145. Corrective Action as it applies to ot residents- all residents have the potential sexual misconduction and that any potential sexual misconduction between residents has been invest and reported as appropriate. Date of Completion: December 15 2015 Recurrence will be prevented by: Somembers have been educated on reportable to OHFC and that the reneeds to be completed immediated the investigative report following with days. Random audits will be completed and then weekly from the monthly. The QAF committee will determine when the	her otential etice. sure ct igated eth, Staff what is eport y, with thin 5 eleted for one		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMPLETED	
		245368	B. WING		<del></del>	11/(	06/2015
GRAND	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE BRAND RAPIDS, MN 55744		
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F 225	the MDS assessment R148's The Activitie Assessment (CAA)	g behaviors 4-6 days during ent period. es of Daily Living Care Area dated 12/29/14, indicated	F 2	25	may be discontinued. Corrective Action will be monitored DON or Designee	by:	
		mbulate independently without e device and she was at risk					
	R148 was diagnose risk for further cogn progression. R148	48's Cognition CAA dated 12/29/15, indicated 48 was diagnosed with dementia and was at k for further cognitive decline due to disease ogression. R148 had difficulty communication ants/needs to others and the staff were to ticipate her needs.					
	was at risk for falls, nursing unit and wa from harm. The ca intervene and sepa concerns were iden	ated 12/26/14, indicated R148 wandered throughout the sunable to remove herself re plan directed staff to rate resident as safety tified, to ensure R148 was not d to keep the environment					
	R145 was diagnose pulmonary disease impairment. The MI						
	R145's care plan da	ated 3/31/15, identified a					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245368	B. WING _		11	1/06/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
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F 225	concern related to intimacy / courtship female residents re	R145 attempting to have behaviors directed towards esiding in the community. The t courtship behaviors with the	F 22	25			
	Review of R148's F following:	Progress Notes revealed the					
	Rivers Community resident with deme down R148's pants separated the resid continue to monitor intervene as neces complete an incide	5 p.m. R148 was found in the seated next to R145 (a male ntia). R145 had his hand at the staff members lents and directed the staff to R148's whereabouts and sary. The facility did not not report, complete a thorough ported it to the State Agency,					
	stated R148 had in year. She stated so other resident room that did not belong staff kept an eye or	10 p.m. family member (FM)-A creased wandering in the past he was aware R148 entered as and often picked up items to her. She stated the facility at R148 as best as possible. It is any concerns related to all touch.					
	(LPN)-I stated R14- Neighborhood and altercations with oth when that happene	8 p.m. licensed practical nurse 8 wandered around the Lakes at times would have her residents. She stated d, the residents were tated if she had noticed					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION IG		COMPLETED		
		245368	B. WING _		11	/06/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 225	be separated. She being involved with	esidents, the residents would stated she was aware of R148 resident to resident d not observed any of the	F 22	25			
	stated R148 contin on the unit. AA-A st disrupted other res	p.m. activity aide (AA)-A uously wandered and paced ated she did not feel R148 idents and when she noticed he tried to engage R148 in a					
	stated R148 wande did not seem to be residents nor did th	p.m. nursing assistant (NA)-H ered daily. She stated R148 afraid of any of the other e other residents seem to be e stated she separated the v a concern.					
	(LSW)-A stated she any concerns relate concerns on the La	p.m. licensed social worker e had not been made aware of ed to resident to resident kes Neighborhood. Therefore, y investigations that may have					
	(RN)-A stated the a occurred with other therefore, the resid and separated. Sh were decreased who dementia care units	6 p.m. registered nurse altercations involving R148 residents with dementia ents were just to be observed e stated R148's behaviors nen the doors between the two is were closed because R148 to open the doors which					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245368	B. WING		11	/06/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 225	residents (R145). I put any other interv	age 5 aviors with some of the male RN-A stated the facility had not rentions in place to increase the Lakes Neighborhood.	F 22	5				
	facility had not increase the Lakes Neight decrease resident to ensure resident satinew intervention in	4 p.m. LSW-A stated the eased staffing or supervision aborhood in an attempt to to resident altercations and fety. LSW-A stated the only aplemented was to close the two dementia units.						
	(DON) stated the famembers education residents with dem staff and the kitche	7 p.m. the director of nursing acility had provided staff in regarding approaching entia. She stated the activity in staff had also received alld assist with the residents as						
	to immediately report / mistreatment to the indicated resident to	e Prevention Plan directed staff ort all suspected maltreatment ne State Agency. The plan o resident altercations would residents acted "willfully."						
	was to report any c resident potential s residents were see stated R148 and R as they were not in with any other resid	p.m. LSW-A stated the facility oncerns related to resident to exual misconduct if the king each other out. LSW-A 145 had sought each other out volved with sexual misconduct dents. LSW-A verified the bove should have been						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245368	B. WING			11/(	06/2015
GRAND	PROVIDER OR SUPPLIER			92	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE 3 RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 F 226	Continued From pa investigation and re directed by the polic 483.13(c) DEVELO ABUSE/NEGLECT	eported to the State Agency as cy. P/IMPLMENT	F 2				12/15/15
SS=D	The facility must de policies and proced mistreatment, negle	evelop and implement written					
	by: Based on interview facility failed to follor related to investigat of potential residen misconduct to the Sincidences reviewe (R145, R148) review	equipment is not met as evidenced on interview and document review, the ailed to follow their policy and procedures to investigating and reporting incidences nitial resident to resident sexual duct to the State agency for 1 of 3 ces reviewed and for 1 of 2 residents R148) reviewed for abuse and neglect.			Corrective Action- OHFC has been notified of the potential sexual misco of residents 148 and 145. Corrective Action as it applies to oth residents- all residents have the pot to be effected by this deficient praction An audit has been completed to asset that any potential sexual misconduct between residents has been investigated.	er ential ice. sure	
	The facility's undated Abuse Prevention Plan directed staff to report all suspected maltreatment / mistreatment immediately to the State agency. The plan identified resident to resident altercations would be reportable if the residents acted "willfully."  R148's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R148 was diagnosed with dementia, anxiety disorder, depression and seizure disorder. The MDS also indicated R148				and reported as appropriate. Date of Completion: December 15th 2015 Recurrence will be prevented by: Something the members have been educated on working the investigative report following with days. Random audits will be completed in the month and then monthly. The QAPI	taff that is port with thin 5 eted or one	
					committee will determine when the amay be discontinued Corrective Action will be monitored to DON or Designee	audits	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245368	B. WING			11/06/2015		
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE BRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 226	had severe cognitive extensive assist for supervision - limited ambulating. The MI displayed physical adays and wandering the MDS assessment (CAA) R148's The Activitie Assessment (CAA) R148 was able to a any type of assistive for falls.  R148's Cognition CR148 was diagnose risk for further cogr progression. R148 wants/needs to othe anticipate her need R148's care plan days at risk for falls, nursing unit and was rom harm. The call intervene and sepaconcerns were identiced.	e impairment, required activities of daily living and dassistance of one staff while DS also indicated R148 aggression towards other 1-3 g behaviors 4-6 days during ent period.  es of Daily Living Care Area dated 12/29/14, indicated mbulate independently without e device and she was at risk  AA dated 12/29/15, indicated ed with dementia and was at itive decline due to disease had difficulty communication ers and the staff were to		226				
	R145 was diagnose pulmonary disease impairment. The M	OS dated 8/6/15, indicated ed with chronic obstructive and had moderate cognitive DS indicated R145 required ee with activities of daily living						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/0	06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD THE APPROP	BE .	(X5) COMPLETION DATE
F 226	concern related to I intimacy / courtship female residents re	red dementia or cators.  ated 3/31/15, identified a R145 attempting to have behaviors directed towards siding in the community. The courtship behaviors with the	F 2	26			
	"nonconsensual."  Review of R148's Pfollowing:  -On 3/17/15, at 3:4! Rivers Community resident with demendown R148's pants separated the resid continue to monitor intervene as necess complete an incider	Progress Notes revealed the seated next to R145 (a male note). R145 had his hand had not not report, complete an orted it to the State Agency.					
	stated R148 had inc year. She stated sh other resident room that did not belong staff kept an eye or FM-A did not expre- inappropriate sexua	O p.m. family member (FM)-A creased wandering in the past ne was aware R148 entered as and often picked up items to her. She stated the facility in R148 as best as possible, as any concerns related to all touch.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/	06/2015
	RAND VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ç	STREET ADDRESS, CITY, STATE, ZIP CODE 023 HALE LAKE POINTE GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Neighborhood and altercations with oth when that happene separated. LPN-I st concerns with the robe separated. She being involved with	at times would have ner residents. She stated d, the residents were tated if she had noticed esidents, the residents would stated she was aware of R148 resident to resident d not observed any of the	F2	226			
	stated R148 continuon the unit. AA-A st disrupted other resi	p.m. activity aide (AA)-A uously wandered and paced ated she did not feel R148 dents and when she noticed ne tried to engage R148 in a					
	stated R148 wande did not seem to be residents nor did th	p.m. nursing assistant (NA)-Hered daily. She stated R148 afraid of any of the other e other residents seem to be estated she separated the via concern.					
	(LSW)-A stated she any concerns relate concerns including on the Lakes Neigh	p.m. licensed social worker e had not been made aware of ed to resident to resident the sexually related incidents aborhood. Therefore, was not ation had been completed.					
	(RN)-A stated the a occurred with other	6 p.m. registered nurse Itercations involving R148 residents with dementia ents were just to be observed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	NG	CON	(X3) DATE SURVEY COMPLETED	
	245368	B. WING	·····	11/	06/2015	
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COL 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE	
and separated. She were decreased who dementia care units had not attempted to decreased the behaves identically the supervision on the Lakes Neight decrease resident to ensure resident safe new intervention im	e stated R148's behaviors en the doors between the two were closed because R148 to open the doors which twiors with some of the male RN-A stated the facility had not entions in place to increase he Lakes Neighborhood.  4 p.m. LSW-A stated the eased staffing or supervision borhood in an attempt to or resident altercations and ety. LSW-A stated the only plemented was to close the	F2	26			
(DON) stated the famembers education residents with demestaff and the kitcher training so they couneeded.  On 11/5/15, at 2:05 was to report any coresident potential seresidents were seek stated R148 and R1 as they were not inwith any other residents were residents were seek at the training the training with any other residents were not inwith any other residents.	cility had provided staff regarding approaching entia. She stated the activity in staff had also received lid assist with the residents as p.m. LSW-A stated the facility oncerns related to resident to exual misconduct if the king each other out. LSW-A 45 had sought each other out rolved with sexual relations ents. LSW-A verified the					
I C a Charlet Office to Contract to Contra	SUMMARY STATE (EACH DEFICIENCY REGULATORY OR LS)  Continued From pagand separated. Shewere decreased who dementia care units had not attempted to decreased the behavesidents (R145). Fout any other interventies and not attempted to decrease decreased the behavesidents (R145). Fout any other interventies and not attempted to decrease resident to ensure resident safenew intervention implementation of the Lakes Neighbors between the total consumer seducation residents with dementiation of the consumer seducation residents with dementiation of the consumer seducation of the consumer seducation residents with dementiation of the consumer seducation of the consumer se	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 10 and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed because R148 had not attempted to open the doors which decreased the behaviors with some of the male residents (R145). RN-A stated the facility had not out any other interventions in place to increase the supervision on the Lakes Neighborhood.  On 11/5/16, at 12:14 p.m. LSW-A stated the facility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations and ensure resident safety. LSW-A stated the only new intervention implemented was to close the doors between the two dementia units.  On 11/5/15, at 12:17 p.m. the director of nursing (DON) stated the facility had provided staff members education regarding approaching residents with dementia. She stated the activity staff and the kitchen staff had also received training so they could assist with the residents as	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 10 and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed because R148 had not attempted to open the doors which decreased the behaviors with some of the male residents (R145). RN-A stated the facility had not but any other interventions in place to increase the supervision on the Lakes Neighborhood.  On 11/5/16, at 12:14 p.m. LSW-A stated the racility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations and ensure resident safety. LSW-A stated the only new intervention implemented was to close the doors between the two dementia units.  On 11/5/15, at 12:17 p.m. the director of nursing (DON) stated the facility had provided staff members education regarding approaching residents with dementia. She stated the activity staff and the kitchen staff had also received training so they could assist with the residents as needed.  On 11/5/15, at 2:05 p.m. LSW-A stated the facility was to report any concerns related to resident to resident potential sexual misconduct if the residents were seeking each other out. LSW-A stated R148 and R145 had sought each other out as they were not involved with sexual relations with any other residents. LSW-A verified the nocident as indicated above, should have been investigated and reported to the State agency as	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 10 and separated. She stated R148's behaviors were decreased when the doors between the two dementia care units were closed because R148 and not attempted to open the doors which decreased the behaviors with some of the male residents (R145). RN-A stated the facility had not out any other interventions in place to increase he supervision on the Lakes Neighborhood.  Con 11/5/16, at 12:14 p.m. LSW-A stated the acility had not increased staffing or supervision on the Lakes Neighborhood in an attempt to decrease resident to resident altercations and ensure resident safety. LSW-A stated the only new intervention implemented was to close the doors between the two dementia units.  Con 11/5/15, at 12:17 p.m. the director of nursing (DON) stated the facility had provided staff members education regarding approaching residents with dementia. She stated the activity staff and the kitchen staff had also received raining so they could assist with the residents as needed.  Con 11/5/15, at 2:05 p.m. LSW-A stated the facility was to report any concerns related to resident to resident potential sexual misconduct if the residents were seeking each other out as they were not involved with sexual relations with any other residents. LSW-A verified the notident as indicated above, should have been nvestigated and reported to the State agency as	STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE  GRAND RAPIDS, MN 55744    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11/06/2015
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	
(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 APPROPE DEFICIENCY)	BE COMPLÉTION
F 278 F 278 SS=D	483.20(g) - (j) ASS ACCURACY/COOF The assessment m	_	F 278		12/15/15
	A registered nurse each assessment v participation of hea				
	A registered nurse assessment is com	must sign and certify that the pleted.			
		o completes a portion of the sign and certify the accuracy of assessment.			
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each asswillfully and knowin to certify a material resident assessme	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each			
	Clinical disagreeme material and false s	ent does not constitute a statement.			
	by: Based on observative review, the facility for Data Set (MDS) as coded to reflect the	NT is not met as evidenced tion, interview and document ailed to ensure the Minimum sessment was accurately resident's range of motion of 5 residents (R23) reviewed		Corrective Action- R 23 has been re-assessed for ROM needs and th plan has been updated accordingly. MDS has been reviewed and correct appropriately reflect the resident ne	The cted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11/06	6/2015
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 123 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	O BE	(X5) COMPLETION DATE
F 278	for ROM.  Findings include:  R23's quarterly MD R23 was diagnosed severe cognitive imindicated R23 requactivities of daily living motion on one side  R23's annual MDS R23 had limited RC body. The Activities Assessment (CAA) this MDS.  R23's Nursing Asseindicated R23 had of her upper body a lower extremities.  On 11/4/15, at 7:08 and NA-H were obseed into a chair via hands were observ (loose) fisted positimove her arms or his transfer.  -At 7:15 a.m. NA-H sweater and bilater arms. R23 did not shoulders and elbo assist with the appl R23's hands remain	S dated 9/29/15, indicated d with dementia and had pairment. The MDS also ired total assistance with all ing and had limited range of	F 278	Corrective Action as it applies to or residents- All residents with ROM have the potential to be effected by deficient practice. An observations was conducted and any residents on-going ROM needs have been assessed to assure that they are rethe appropriate care. Care plans a MDS have been updated as appropriate.  Date of Completion: December 15 Recurrence will be prevented by: members have been educated on need to assess and treat residents ROM needs. Staff members have educated on the need to complete MDS accurately according to reneeds and to assure accuracy of oplans. All staff educational meetin held on November 30, 2015. Rank ROM observational audits will be completed daily for 2 weeks and the weekly for one month and then month and then month and then month and the month and the many be discontinued. Corrective Action will be monitored DON or Designee	needs y this al audit with ecceiving and 5, 2015 Staff the s with e been sident are gs were dom nen onthly. e QAPI e audits	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245368	B. WING		1	1/06/2015
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE				STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE
F 278	R23 to eat the brea observed to be una upper extremitiesAt 9:15 a.m. NA-G transfer R23 from the mechanical lift. Once assistance with incomposition clamped toget were observed position (foot drop) participate with the On 11/4/15, at 1:10 stated R23 received week during activities staff completed arm 20 minutes each date and legs had been on the state of the state	kfast meal. R23 was ble to independently move her and NA-F were observed to he chair to bed via a ce in bed, R23 received ontinence cares. R23's knees with her legs observed to gether during the cares. R23's to be in a pointed downward. R23 was not observed to cares.  p.m. activity aide (AA)-A d passive ROM six days a es. She stated the activity and leg repetitions for about ay. She stated R23's arms "tight" but they were much peared stronger after receiving	F 2	78		
	provide morning ca to open R23's left h move R23's left sho The left elbow did r was able to open R fingers did not exte right elbow did not of was able to be mov under the right arm NA-G stated R23's to be fully extended -At 6:15 a.m. NA-H with cares. NA-H a	upper extremities were unable				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED		
		245368	B. WING			11	/06/2015
	PROVIDER OR SUPPLIER			923 HALE LAK	SS, CITY, STATE, ZIP COE E POINTE IDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRI I CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	remained in a point drop) as staff applie were observed to rebent at the knees a cares and applied FR23's legs had always legs had limitation arms and legs. NAhad not changed in On 11/5/15, at 9:20 stated she complete perform ROM exerces the stated all MDS the Nursing Assess completed by RN-A-At 9:25 a.m. RN-D ROM for R23 while R23 displayed limitational bilateral shoulders, and feet.  -At 9:40 a.m. RN-D coded correctly as illimitations in ROM in extremities. At this she had completed Assessment form a	ed downward position (foot ed R23's socks. R23's legs emain together and slightly is the NAs completed perineal R23's pants. NA-H stated ays been "tight" when NA-H stated she had worked in past two years and R23 had in sin her ability to move her H stated R23's ROM abilities the past year.  a.m. registered nurse (RN)-D ed the MDS but did not cises on dependent residents. coding was transcribed from ment documentation	F2	78			
	identified concerns were all new since						
	On 11/6/15, at 8:30	a.m. RN-C verified RN-D did					

AND BLAN OF CORRECTION INTERPRETATION NUMBERS		, ,	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245368	B. WING _	····	11/	/06/2015
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	not perform ROM e a residents' ROM a complete the MDS Assessment docum Nursing Assessment the assessment RN when completing the above. RN-C stated nursing units to reviously if the document RN-C stated RN-D ROM for R23 prior.  On 11/6/15, at 8:42 located R23's past Physical Therapy Eidentified R23 had I the lower extremitie feet. A passive RO 6/28/14, at which timbilateral limitations hands. RN-D verified correctly.  The Resident Instruinstruction manual MDS, dated 4/2012 the MDS should coresidents ability to prevent ally directing the or physically assistimovements by supplied and guiding it through the RAI manual, incomplete, the RN winformation entered	ge 15 xercises in order to determine bilities, rather, was to according to the Nursing tentation. RN-C verified the at completed on 9/28/15, was I-D would have referred to e quarterly MDS as indicated if RN-D would only go onto the few resident areas of concernitation contraindicated itself. was not expected to complete to the completion of an MDS.  a.m. RN-D stated she had therapy evaluations. R23's valuation dated 3/27/13, imitations in ROM bilaterally in its including hips, knees and M program was established me R23 was identified with in her shoulders, arms and at R23's MDS was not coded at R23's MDS was not coded at the RN completing mprehensively assess the perform ROM by either e resident to complete a task, and the resident with the corting his or her extremity gh the joint ROM. In addition, dicated by signing the MDS as was certifying that the lon the MDS, to the best of cost accurately reflected the	F 2'	78		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245368	B. WING		11/06/2015
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE  123 HALE LAKE POINTE  GRAND RAPIDS, MN 55744	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 279 F 279 SS=D	483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive pla.  The facility must deplan for each reside objectives and time medical, nursing, a needs that are identical assessment.  The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any significant to the second control of the	(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 279 F 279		12/15/15
	§483.10, including under §483.10(b)(4)  This REQUIREMENT by: Based on interview facility failed to devrestorative nursing program for 1 of 1 in ROM and for 1 of 1 who required assistant of the required assistant include:	the right to refuse treatment		Corrective Action- R 203 has been re-assessed and an ambulation plan been put in place. R 72 has been re-assessed and an ROM plan has been put in place. The care plans have be updated.  Corrective Action as it applies to othe residents- All residents with ambulation ROM needs have the potential to be effected by this deficient practice. Ar audit was conducted and any residen with ambulation or ROM needs have	een er on or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245368	B. WING		11/	06/2015
	PROVIDER OR SUPPLIER  VILLAGE			STREET ADDRESS, CITY, STATE 923 HALE LAKE POINTE GRAND RAPIDS, MN 5574	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279	9/17/15, indicated dementia, osteoart impairment. The Mand had limitations extremities.  R72's medical recoregistered nurse (Frestorative program complete was initial included passive raweek, provide abduextension to bilater fingers, hips, kneed had lower extremities, vrequired total staff mobility and was anote indicated a reup in order to preven the record in th	R72 was diagnosed with hritis and had severe cognitive IDS indicated R72 did not walk in ROM to both lower ord note dated 9/5/15, by RN)-B indicated a new in for the nursing assistants to ated. The restorative program ange of motion six times per auction, adduction, flexion and real shoulders, elbows, wrist, is, ankle and toes daily.  Ord note dated 9/9/15, by RN-D ROM limitations to bilateral was wheelchair dependent and assistance for wheelchair trisk for decline in ROM. The storative program would be set	F 2	re-assessed to assure the appropriate care. being audited to assuradequately reflected. been updated as approate of Completion: In Recurrence will be presented to assess and transmitted and ROM members have also be care plan development educational meeting where November 30, 2015. Be completed by the Nand/or DON daily for 2 weekly for one month. The QAPI committee with a audits may be discontractive Action will be DON or designee.	Care plans are te that cares are Care plans have opriate. December 15, 2015 evented by: Staff educated on the eat residents with needs. Staff een educated on the An all staff was held on Random audits will lurse Managers weeks and then and then monthly, will determine when continued	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245368	B. WING			11/0	06/2015
	NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES			92	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE BRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	toileting, and ambuing R203's physical the dated 9/11/15, indice meals.  R203's Rehabilitative indicated R203 was bathroom as able would walker.  R203's care plan da R203 with a front woone staff. The care restorative nursing ambulation.  On 11/2/15, at 5:00 R203 was observed room.  On 11/4/15 at 7:00 assisted R203 with 4 wheeled walker (a move from the bed chair, while NA-A at assist R203. NA-A room for breakfast.  On 11/5/15, at 6:05 rarely attempted to not go for walks any could walk a couple standing with her would taking several steps recliner. NA-A state and needed to sit didue to being unstead			779			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/06/2015	
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE	
F 280 SS=D	verified R203's care restorative nursing stated R203 was to recommended by the nursing assistation the computer thaware of R203's and The Care Planning staff to provide care individual care pland 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannic changes in care and A comprehensive as interdisciplinary teal physician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident representative and representative	5 a.m. RN-A unit manager e plan did not include the plan / walking program. RN-A be on a walking program as ne PT however, the task for ints to complete was never put neretofore the NA's were not inbulation program.  policy dated 9/2013, directed according to the residents'.  0(k)(2) RIGHT TO NNING CARE-REVISE CP in eright, unless adjudged erwise found to be in the laws of the State, to lang care and treatment or	F2			12/15/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION		E SURVEY PLETED
		245368	B. WING _	····	11/0	06/2015
_	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO T  DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From pa	age 20	F 28	80		
	by: Based on observareview, the facility finclude the current (PROM) program freviewed for ROM.  Findings include:  R23's care plan dadependent on staff The plan directed snursing services as manager.  The nursing assist program directed a complete PROM wupper and lower extended to sit in her was daughters hand dudid not direct the streceive PROM.  On 11/5/15, at 6:10 provide morning cato open R23's left in to move the should the left elbow did in the left e	tion, interview and document failed to revise the care plan to passive range of motion or 1 of 5 residents (R23)  ted 4/8/15, indicated R23 was for all activities of daily living. Staff to perform restorative is directed by the nurse ant Point of Care (POC) activity staff members to which included stretching to the actremities for ten repetitions. Insure R23 maintained the wheelchair and hold her ring visits. The documentation taff as to which joints were to the actremities for R23. NA-G was able the slightly to wash under it. The context of the context o		Corrective Action- the cahas been modified to refle Passive Range of Motion Corrective Action as it apresidents- All residents were additionally and the passive Range of Motion needs have been re-assessed to assive receiving the appropriate plans have been revised resident needs. Date of Completion: Decently and the plans have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion members have been eduneed to assess and treat Passive Range of Motion Passive Range of Motion Passive Range of Motion Pa	ect the proper program. plies to other with Passive plave the potential icient practice. and any residents otion needs have ure they are care. The care based upon cember 15, 2015 anted by: Staff practed on the residents with a needs. Staff practed on Plan coding. Vised to reflect cational meetings 30, 2015. It will be eas and then do then monthly. It when the audits of the program of the progr	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		` '	E SURVEY PLETED
		245368	B. WING			11/0	06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 280	90 degrees. The let the left shoulder was order for the staff to NA-G stated R23 up to be fully extended At 6:15 a.m. NA-H cares. NA-H and N cares. R23's feet ru (foot drop) as the stated R23's legs together and slightly completed perineal NA-H stated R23 has completing cares. at the facility for the always had limitation	offt elbow did not extended and as able to be moved for R23 in wash under the arm. pper extremities were unable	F 2	80			
	receive passive ran seated in her wheel gently move R23's AA-A completed repjoint. She was able hand. The left elbo extend. R23's right but the fingers were straightened. The emoved, but were not extended. At 11:37 and began to do leg moved R23's hip ar seated in the chair. to attempt to do passive seated in the chair.	6 a.m. R23 was observed to ge of motion from AA-A while Ichair. AA-A was observed to hands, elbows and shoulders. Detitive movements on each to fully extend R23's left wand shoulder did not fully hand was able to be opened, to observed to be elbow and shoulder were observed to be fully a.m. AA-A knelt on the floor gexercises for R23. AA-A and knees while she was At no time did AA-A observed ssive ROM to R23's feet.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	` '	SURVEY PLETED
		245368	B. WING	<del></del>	11/(	06/2015
GRAND	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALE LAKE POINTE  GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280 F 281	to complete passive The Care Planning the staff to revise the resident need.	evised to direct the staff how	F 280			12/15/15
SS=D	PROFESSIONAL S  The services provid must meet profession	TANDARDS  ed or arranged by the facility onal standards of quality.				
	by: Based on observat review, the facility fa practice when admi	ion, interview and document ailed to follow the standard of nistering medications for 1 of bserved for medication tices.		Corrective Action- R 61 has been reviewed and the staff member has educated on the proper correct me medication administration. Corrective Action as it applies to ot residents- all residents who receive medications have the potential to be effected by this deficient practice. medication pass audit was conductive.	thod of her e be A ted and	
	(LPN)-C was obsernmedications which is milligrams (mg) tab thinning medication reducing medication (cholesterol lowerin 50 mg tablet (blood LPN-C placed the neup and handed the assistant (TMA)-A.  -At 4:33 p.m. TMA-A	p.m. licensed practical nurse ved to prepare R61's ncluded Coumadin 2 let (anticoagulant-blood), Pepcid 20 mg tablet (acid n), Simvastatin 40 mg tablet g medication) and Metoprolol pressure/heart medication). nedications in a medicaiton e cup to trained medication cup and which was not observable		staff members are being monitored medication pass. Nurse Managers DON are responsible to perform th audits and correct issues as noted audit.  Date of Completion: December 15 Recurrence will be prevented by: Smembers have been educated on the proper way to pass medications. A educational meetings held on Nove 30, 2015. Random medication paraudits will be completed daily for 2 and then weekly for one month and monthly. The Nurse Managers and	s and e on 5, 2015 Staff the All staff ember ass weeks	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		E SURVEY MPLETED
		245368	B. WING _		11/	06/2015
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 281	R61 the medication -At 4:36 p.m. TMA-cart and LPN-C ask R61 the medication medications. TMA-medications. LPN-C this, but R61 does rhis room, and so it someone else to girdid not sign off on thad been given. LP trained medication administer medication administer medicatis should have dished administered them.  On 11/5/15, at 1:51 (DON) verified medithe nurse who dished stated being LPN-C	cation cart and administered s. A returned to the medication and TMA-A if she had given s and if R61 had taken the A verified R61 had taken the C stated, "I don't usually do not always let everyone into is easier to give them to be [to R61]." LPN-C stated she medications until after they N-C verified TMA-A was a assistant and could dish and ons. LPN-C verified TMA-A R61's medications then	F 28	Don will be responsible to compliant audits. The QAPI committee will determine when the audits may discontinued Corrective Action will be monitor DON or Designee	pe	
F 282 SS=E	and made sure the DON verified the far medication adminis  The facility policy, Madministration-Gen 2006, indicated the medication dose for person who was to 483.20(k)(3)(ii) SER PERSONS/PER CATThe services provide	medications were given. The cility policy related to tration was not followed.  Medication eral Guidelines Policy dated person who prepared the radministration was the administer the dose.  RVICES BY QUALIFIED	F 28	2		12/15/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245368	B. WING			11/0	06/2015
	PROVIDER OR SUPPLIER  VILLAGE			92	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE FRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	accordance with eacare.  This REQUIREMEN	ge 24 ch resident's written plan of NT is not met as evidenced	F 2	82			
	review, the facility facility facility facility fresidents (R99, R23 assistance with ora (R23) who required for 2 of 2 residents	ion, interview and document ailed to provide services as vidual care plan for 2 of 2 in the sample who required I cares, for 1 of 3 residents assistance perineal cares and (R122, R65) who were to nursing rehabilitation services.			Corrective Action- R 23 has been reassessed for perineal care needs and R 99 have been re-assessed for care needs. R 122 an R 65 have been re-assessed for their rehab service needs. All of these residents are neceiving the proper cares. The caplans of these residents are current Corrective Action as it applies to ot residents- all resident with perinea	or oral been s ow re t. her	
	Findings include: R99 did not receive care plan.	oral cares as directed by the			care and rehab services needs have potential to be effected by this deficient practice. A resident cares audit we conducted to assure that the reside with these needs are receiving the care. The care plans of these residence been updated as appropriate.	ve the cient as ents proper dents	
		ed 12/17/14, directed staff to for oral cares twice a daily and			care plans policy was reviewed and revised as appropriate.  Date of Completion: December 15 Recurrence will be prevented by: 9 members have been educated on the care plans and the care plans are planted as a policy was reviewed and revised as appropriate.	d , 2015 Staff	
	assistant (NA)-G was morning cares. At oral caresAt 7:26 a.m. R99 was room for breakfastAt 8:50 a.m. after the from the breakfast.	10 a.m. until 7:26 a.m. nursing as observed to assist R99 with no time did NA-G offer R99 vas assisted to the dining the meal, NA-H assisted R99 table into the restroom. At no erved to offer oral cares.			need to provide the proper cares. staff educational meetings were he November 30, 2015. Random au related to peri cares, oral cares and needs (care plan implementation a will be completed daily for 2 weeks then weekly for one month and the monthly. The Nurse Managers an DON are responsible for the audits nursing staff will be responsible to conduct the audits with oversight b	All ld on dits d rehab udit) and n d/or . The	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	were to be complet verified she had no cares after the mea.  On 11/5/15, at 9:14 not offered or providate during mornin.  On 11/5/15, at 9:20	a.m. NA-H stated oral cares ed before breakfast. She t offered or provided R99 oral al.  a.m. NA-G verified she had ded R99 oral cares and should g cares.  a.m. registered nurse (RN)-A	F 2	282	DON. The QAPI committee will determine when the audits may be discontinued Corrective Action will be monitored DON or Designee	by:	
	verified staff should have completed R99's oral cares as directed by the care plan.  R23 did not receive oral cares or perineal cares as directed by the care plan.						
	not have teeth and cares twice a day. staff to provide peri	ted 1/7/15, indicated R23 did directed staff to provide oral The care plan also directed neal cares after each and to utilize protective skin					
	provide R23 with m observed to be tota complete the task a communicate. -At 6:20 a.m. NA-H assisted NA-G with -At 6:30 a.m. R23 v a wheelchair via a f	a.m. NA-G was observed to orning cares. R23 was ally dependent upon staff to and was unable to verbally entered the room and the cares. was transferred from the bed to fully body mechanical lift. was wheeled to the breakfast					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/0	06/2015
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 223 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	room to her room. transferred R23 to 1-At 9:00 a.m. NA-H check R23's incont brief was observed NAs removed the brook time were the Nas ocares.  On 11/5/15, at 9:05 were to be complet perineal cares were incontinent episode provided R23 oral odirected by the care of the completed oral.  On 11/5/15, at 9:15 not completed oral.  On 11/5/15, at 9:20 and perineal cares directed by the care of	wheeled R23 from the dining NA-G and NA-I assisted R23 bed. and NA-I were observed to inent brief. R23's incontinent saturated with urine. Both orief and applied a new one. At As observed to cleanse R23's ring the incontinent episode observed to provide R23 oral.  a.m. NA-H stated oral cares ed before the meal and exto be provided after an example. NA-H verified she had not cares or perineal cares as explan.  a.m. NA-G verified she had cares during morning cares.  a.m. RN-A stated oral cares were to be completed as explan.  we rehabilitation services six exected by the care plan/rehab.	F 2	282			
	refer to R122's rest documentation for s						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(		SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD E IE APPROPRI		(X5) COMPLETION DATE
F 282	3/25/15, indicated F range of motion (Rodue to left sided he R122's Restorative included the additions splint/brace training	R122 was to receive active DM) to right upper extremities miplegia and weakness. program dated 5/14/15, n of R122 was to receive to left hand and gentle ist. Both programs were to be	F 2	82			
	bed. R122 stated si services six days a getting the services Mon-Wed. (11/2/15 rehab services. However, the being she had atter get rehab services, department was to and that was not hat weeks, the department only three days and the doors and there	a.m. R122 was observed in the was to receive rehab week and she had not been at R122 stated this week, -11/4/15) she had not received wever, R122 stated yesterday attend a Christian activity and add the activity, she could not R122 also stated the rehab be open seven days a week appening. R122 stated some nent cut down to being open I someday's they just closed was no rehab provided staff were pulled to work on					
	verified R122 had n as indicated on her pulled from the reha work on the floor. R that happened, the	5 p.m. rehab aid/TMA-A not been receiving her rehab restorative plan due to being ab department and having to dehab aid/TMA-A stated when rehab doors were closed and ded for any of the residents.					
		0 a.m. RN-B reviewed and e plan and rehab directives					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245368	B. WING		11/0	06/2015
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 223 HALE LAKE POINTE GRAND RAPIDS, MN 55744	,	
(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 APPROPROPRIES OF THE APPROPRIES OF	D BE	(X5) COMPLETION DATE
	and stated R122 was days per week as chad not been received	age 28 as to receive the services six lirected. RN-B verified R122 ving rehab services as directed aff being pulled from the rehab	F 282			
	R65 did not receive a week as directed	rehabilitation services 6 days by the care plan.				
	R65's care plan dated 8/24/15, directed staff to refer to R65's restorative nursing and tasks in point click care (PCC) for specific program information. The program directed staff to provide restorative ambulation which consisted of Nu step level 4's 10 minutes and lower extremity 3 pound ankle weights-kick and march's 30 repetitions seven day per week. The program also included restorative dressing and grooming which included active ROM bike 200 turns, Red Flex bar 20 repetitions, clothes pin and cord sort 1 time and free weights 30 repetitions which was to be provided six days a week.					
	receiving rehab ser be receiving the se department was clo and Sunday (11/1/1 and part of Tuesda	a.m. R65 stated she was not vices. R65 stated she was to rvices six days a week and the used both Saturday (10/31/15) 5) and also Monday (11/2/15) y (11/3/15). R65 stated the ulled to work the floor so they ab doors.				
	days when Rehab	a.m. LPN-F stated there were was closed due to being short				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  (2	X3) DATE SURVEY COMPLETED
		245368	B. WING _		11/06/2015
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALE LAKE POINTE  GRAND RAPIDS, MN 55744	
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F 282		ened on some weekdays. vas very loyal to her rehab	F 28	2	
	R65's rehab plan di per week but R65 w	p.m. rehab aide/TMA-A stated rected R65 to attend six days would come seven days a ed R65 had not received by the care plan.			
	a rehab program wl day per week. RN-E	0 a.m. RN-B verified R65 had hich was to be provided six 3 confirmed R65 had not es as directed by the care			
F 309 SS=D	staff to provide care individual care plan	CARE/SERVICES FOR	F 30	9	12/15/15
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment			
	by: Based on observat	NT is not met as evidenced ion, interview and document ailed to to ensure there was		Corrective Action- R 72 is now recei the proper w/c positioning. R 117 is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	coordination of carreviewed for hospic facility failed to propositioning for 1 of wheelchair position  Findings include:  Hospice  R117 was receiving facility and hospice the care and service facility and hospice the care and service for the care	e for 1 of 1 (R117) resident ce services and in addition the vide proper wheelchair 1 resident (R72) reviewed for	F 309	receiving the appropriate Hospice and Grand Village and Hospice a working together to assure care coordination. The care plans are Corrective Action as it applies to residents- all residents in need of positioning and those on Hospice the potential to be effected by this deficient practice. An audit of caservices was conducted to assur residents with these needs are rethe proper care. The care plans residents have been updated as appropriate. OT will evaluate the resident sw/c positioning needs Date of Completion: December Recurrence will be prevented by: members have been educated on need to provide the proper cares educational meetings were held of November 30, 2015. Random a cares and services, including w/c positioning will be completed by Managers and/or the DON daily for the proper cares.	current. other w/c have s res and e that the eceiving of these  . 15, 2015 Staff n the . All staff on udits of  Nurse or 2	
	9/16/15, indicated l cancer, anemia, m The MDS indicated of staff for all activi	ated 6/22/15, indicated hospice		weeks and then weekly for one methen monthly. The QAPI commit determine when the audits may be discontinued. Corrective Action will be monitored DON or Designee.	tee will e	
	9/8/15, indicated a	re plan for the HHA updated on HHA would visit one to two provide mouth care, fingernail				

	OF DEFICIENCIES OF CORRECTION			E SURVEY PLETED			
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 309	needed, positioning tidy room. Facility C date, what discipling visited R117, collaborated R117, collaborated R117, collaborated R117, collaborated R117, collaborated R117, revisited R117 four tires on 8/26/15, the house assisted with lunch with facility staff was next planned visit woon 9/9/15, the HH with lunch. The seefacility staff was bla planned visit was a on 10/23/15, the collaboration with fanext planned visit woon 10/30/15, the house sleeping and the faconcerns. The sect facility staff was bla planned visit was a on 11/5/15, at appropriate (RN) -B was of care with hospice R117. RN-B stated and the facility did rhow often the hospice On 11/6/15 at 8:30	Sising, transferring, bathing as a toileting, socialization and contact forms included the visit of from the hospice agency oration with facility staff and contact forms from 8/17/15, wealed the hospice HHA had mes as follows:  Spice HHA noted P117 was a spice HHA noted P117 was a laso blank. A noted R117 was assisted ction for collaboration with and the section for next laso blank. HHA had documented acility staff but the section for was blank. HHA indicated R117 was cility nurse reported no ion for collaboration with nk and the section for next laso blank.	F 3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245368	B. WING _		11	/06/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	non-verbal, eyes we and R117 appeared	f her breakfast. R117 was ere closed most of the time	F 30	9			
	hospice HHA provious facility. NA-E stated when the HHA visit HHA came, sometimes	out interventions or cares the ded for R117 when at the ded for R117 when at the ded for R117 when at the ded and depending on when the mes they would give R117 and ey came at mealtime they with meals.					
	RN came to the face explained R117's constant the HHA did visits because their they came when the facility did not known were coming or who providing. RN-B conservices were not were to the services were not were explained.	a.m. RN-B stated the hospice cility last evening, 11/5/15, and are plan. The hospice nurse not have a set schedule for hospice case load varied so ey could. RN-B verified the when the hospice HHA staff at services they would be nfirmed R117's hospice well coordinated or rding to R117's needs.					
	was interviewed on hospice HHA was s Friday but the time HHA's prior visits o The nurse indicated collaborated with the	a.m. R117's hospice nurse the telephone and stated the supposed to visit R117 every varied depending on the f the day and the case load. d the HHA should have le facility staff and their next planned visit would					

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		245368	B. WING	<del></del>	11.	/06/2015	
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F 309	with R117 most day hospice HHAs visit stated she was not	a.m. NA-E stated she worked ys and was not aware the ed R117 on Fridays. NA-E also aware of the hospice and et which would have had the	F 3	09			
	stated hospice age or calendar to indic	0 a.m. the director of nursing ncy's used to have a schedule ated when they would be at at is not the process now, then inged.					
	January 2014, indic participated in the hamber coordinated plan of hospice agency and developed and wou managing pain and symptoms. The car	e Program policy revised cated when a resident nospice program, a ficare between the facility, di resident/family would be ald include directives for lother uncomfortable re plan shall be revised and ary to reflect the patient's					
	Wheelchair position	ning:					
		oning assistance and the ist and identify the need for a chair.					
	9/7/15, indicated Ridementia, osteoart	num Data Set (MDS) dated 72 was diagnosed with hritis, chronic kidney disease The MDS indicated R72 had					

	AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			TE SURVEY MPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 309	required extensive and extensive assis mobility / locomotio MDS also indicated R72's care plan dathad cognitive impair communicating was to anticipate R72's	int, was non ambulatory, assist of two staff for transfers of one staff for wheelchair n on and off the unit. The I R72 was non-ambulatory.  Ited 12/19/14, indicated R72 irment and difficulty ints / needs and directed staff needs. The plan indicated R72	F 30	09		
	utilized a wheelcha to use foot pedals of	as transferred with a E-Z mechanical lift and ilized a wheelchair for mobility and directed staff use foot pedals on the wheelchair if R72 was ut of the room or off unit.				
	7/2/15, and signed R72 was referred to conditions which in posturing and a sig positioning. The platherapy to improve wheelchair position dated 7/30/15, indic on elevating legs repositioning and condated 9/23/15, indic proper positioning of	therapy (OT) care plan dated by OT-A on 8/9/15, indicated of therapy due to multiple cluded dementia, abnormal nificant decline in wheelchair an indicated R72 required skill functional activities of ing. R72's short term goal cated R72 would position feet ests in order to maintain proper nfort. R72's long term goal cated R72 would maintain of legs on elevating leg rest at maintain proper positioning				
	seated in a wheelch the leg rests and re foot pedals instead	15 a.m. R72 was observed nair with feet extended past esting on top of the edge of the of resting flat on the pedals. A A who was the director of				

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		245368	B. WING	·····	11	/06/2015
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	positioned correctly stated R72's wheel	r ified R72's feet were not on the foot pedals. OT-A chair did not fit him and would revaluation for proper	F3	09		
	(LPN)-D stated R72 not wheeled his wh required the use of	5 a.m. licensed practical nurse 2 had a recent decline and had eelchair anymore therefore the foot pedals. LPN-D stated otal staff assistance for all				
	evaluated for whee and at that time foo wheelchair. OT-As followed up on the	2 a.m. OT-A stated R72 was lchair positioning on 7/2/15, t rests were added to the tated the facility should have effectives of R72's foot pedals by were initiated, but it had cracks.				
	seated in a wheelch One of R72's feet w pedal and the other	5 a.m. R72 was observed nair in the television room. vas resting on top of the foot foot had slid off the side of was resting on the floor.				
	stated an evaluation was just completed had motion available was resistive to ran	0 p.m. the physical therapist n of R72's lower extremities and it was determined R72 e in the lower extremities but ge of motion. The PT stated propriately placed on the foot t leave them there.				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245368	B. WING		11/0	11/06/2015	
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309 F 311 SS=D	stated R72's knees sure if the arthritis he declining in range of R72's foot pedals wand stated R72 work wheelchair position also be assessed be pain medication for to be increased or of A policy and proced was requested but 483.25(a)(2) TREA IMPROVE/MAINTA A resident is given a services to maintain	p.m. registered nurse (RN)-B had gotten stiffer and was not had worsened or if R72 was of motion. RN-B confirmed were not appropriate for him ald be evaluated by OT for ing. RN-B stated R72 would by nursing to determine if R72's stiffness of the knees needed changed.  dure for wheelchair positioning was not provided.  TMENT/SERVICES TO	F3			12/15/15	
	by: Based on observative review, the facility for consistently implement improve and/or main abilities for 1 of 1 reviewed for restorative services and for 1 of	ition, interview and document ailed to provide and ment ambulation services to intain residents' ambulation esident (R203) in the sample ative nursing ambulation of 1 resident (R65) in the or rehab nursing services.		Corrective Action- R 203 is being ambulated according to the ambul plan. The care plan was reviewed is current. R 65 is receiving Range Motion. The care plan of R 65 has updated.  Corrective Action as is applies to cresidents- all residents with ambu and ROM needs have the potential effected by this deficient practice, audit of ROM and ambulation plan conducted and care plans updated reflect the current ambulation/ROM	and it e of s been other lation I to be An s was		

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY MPLETED
		245368	B. WING _		11/	06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 311	R203's admission Mated 9/4/15, indicated 9/4/15, indicated mentia, had sever required extensive mobility, transfers, ambulation. R203's Area Assessment of had received physicoccupational therapand independence.  R203's PT dischargindicated R203 was bathroom as able was bathroom as able was to ambulate with assist of one staff. address R203's resulting indicated R203 was bathroom as able was to ambulate with assist of one staff. address R203's resulting indicated R203 into the On 11/4/15 at 7:00 was observed to as NA-A applied a tranand assisted R203 walker (an assistive self from the bed at the control of the cont	Minimum Data Set (MDS) ated R203 was diagnosed with are cognitive impairment and assistance from staff for bed dressing, toileting and Activities of Daily Living Care dated 9/11/15, indicated R203 cal therapy (PT) and by (OT) to increase strength  ge therapy note dated 9/11/15, at to walk to meals.  We Care sheet dated 9/16/15, at to walk to meals and to the with assist of one staff and  lated 11/4/15, indicated R203 th a front wheeled walker and However, the plan did not storative program.	F 31	of the residents. The policy on ambulation and ROM was review revised as appropriate. Date of Completion: December Recurrence will be prevented by members have been educated on need to provide the proper ambulation/ROM program. All seducational meetings were held November 30, 2015. Random ambulation and ROM audits, included in the control of the con	15, 2015 Staff In the staff In	

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING  A. BUILDING			B) DATE SURVEY COMPLETED		
		245368	B. WING _		11/	06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	1	30,2010
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 38	F 31	1		
	rarely attempted to longer went for wal walk a couple of ste walker in front of he several steps to the NA-A stated R203 standing and needs stood up due to be	s a.m. NA-A stated R203 very self transfer any more and no ks. NA-A stated R203 could eps such as standing with her er and transferring taking e wheelchair or the recliner. really leaned forward when ed to sit down shortly after she ing unsteady. NA-A stated it weeks since R203 had walked				
	to be on a walking the PT however, the follow was never pustated she had see walker from the day 10/29/15. At this time R203. R203 was of the day room into the observation, RN-a R203's PT recommerprogram into the control of the con	5 a.m. RN-A verified R203 was program as recommended by e task directive for the NAs to ut into the computer. RN-A en R203 walk with one staff and y room to the dining room on the, NA-A was asked to walk observed to slowly walk from the dining room. Following this stated she was going to in-put the endation for the ambulation omputer so that the NAs would R203's ambulation each day.				
		e range of motion/rehab d on the care plan/nursing n.				
	R65 was diagnosed	DS dated 8/31/15, indicated dwith diabetes, congestive egenerative joint disease. The				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			COMPLETED		
		245368	B. WING _		11	/06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 311	was independent in required limited ass Activities of Daily Lidated 9/11/15, indic participating in reharange of motion (Alindicated during the had received sever services.  R65's Physical The 1/16/15, indicated Five weakness status point click care (PC information. The Reindicated staff were Nu step level 4's 10 three pound ankley repetitions seven divere directed to proand grooming prog 12/15/14, and incluturns, Red Flex barsort once and free program was to be	In Interest in Int	F3	11		

				E SURVEY PLETED			
		245368	B. WING			11/06/2015	
	PROVIDER OR SUPPLIER  VILLAGE			g	STREET ADDRESS, CITY, STATE, ZIP CODE 223 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE
F 311	receiving rehab ser be receiving the ser department was closed and Sunday (11/1/1 and part of Tuesday rehab staff were purious closed the rehabit of staff and it was a verified it also happed LPN-F stated R65 to program and she downward and she	a.m. R65 stated she was not vices. R65 stated she was to rvices six days a week and the beed both Saturday (10/31/15) 5) and also Monday (11/2/15) by (11/3/15). R65 stated the filled to work the floor so they ab doors.  a.m. LPN-F stated there were was closed due to being short is ually on the weekends but bened on some weekdays. Was very loyal to her rehabid not like to miss it.  p.m. rehab aide/TMA-A or plan directed R65 to attend out stated R65 would come. TMA-A verified R65 had not is directed by the care plan as ad been pulled from the rehabidit.  Intelligence was reviewed with and the following was staff, department was closed. If pulled at 8:30 a.m. to work	F	311			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245368	B. WING _		11/06/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALE LAKE POINTE  GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 311	closed -10/27/15, rehab stadepartment all day -10/29/15, pulled all -10/30/15, pulled all -10/31/15, pulled all -11/1/15, pulled all -11/2/15, pulled all -11/3/14, staff was prom 8:00 a.m10:3  On 11/6/15, at 10:20 was to receive rehadirected stated it was maintenance and sinus to be provided	o staff available, department aff were pulled from the I day atil 10:15 a.m. I day day day bulled from the department 30 a.m.  O a.m. RN-B verified R65 had b / restorative services as	F 3	11		
F 312 SS=D	the objective was d resident to achieve level of self-care the motion and ambula the residents' would admission by PT/O determine goals and upon discharge from 483.25(a)(3) ADL O DEPENDENT RES A resident who is un daily living receives	orative Care Policy indicated irected toward assisting each and maintain their highest rough positioning, range of tion. The policy also indicated d be assessed at time of T whereby PT/OT would d level of restorative care in PT/OT therapy services. ARE PROVIDED FOR IDENTS  Thable to carry out activities of the necessary services to tion, grooming, and personal	F 3 <sup>-</sup>	12		12/15/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245368	B. WING		11/0	6/2015	
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALE LAKE POINTE  GRAND RAPIDS, MN 55744		.,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	Continued From pa	ge 42	F 312				
	by: Based on observat review, the facility for with oral cares for 2 the sample who we hygiene. In addition perineal cares for 1 incontinent of urine perineal cares.  Findings include:  R99 did not receive care plan.  R99's significant che (MDS) dated 9/4/15 diagnosed with den disorder. The MDS cognitive impairment extensive to total as daily living. R99's December (CAA) dated 9/15/1 teeth but was a risk bleeding and infection provided R99 oral cousing half strength daily.  R99's care plan dated the sample of the s	ion, interview and document ailed to provide assistance of 2 residents (R23, R99) in re dependent on staff for oral in the facility failed to complete of 1 resident (R23) who was and dependent upon staff for and dependent upon staff for oral cares as directed by the ange Minimum Data Set indicated R99 was mentia, anxiety and seizure also indicated R99 had int, had no teeth and required esistance with all activities of itental Care Area Assessment indicated R99 did not have a for issues with chewing food, ion. The CAA indicated staff cares daily and as needed by mouthwash and oral swabs		Corrective Action- Oral cares have provided to R23 and R 99. The car plans of these residents have been reviewed and updated as appropria Perineal cares have been provided 23. The care plan was reviewed ar updated.  Corrective Action as it applies to oth residents- all residents with oral car perineal care needs have the potent be effected by this deficient practice audit was completed and care plan updated to reflect the oral care need and/or perineal care needs of thes residents. The care plan policy was reviewed and revised as appropriat Date of Completion: December 15 Recurrence will be prevented by: Smembers have been educated on the need to provide the appropriate ora cares. All staff educational meeting held on November 30, 2015. Randoral care and peri care audits will be completed daily for 2 weeks and the weekly for one month and then month and then month and then month of the Nurse Managers and/or DON are sponsible for the audits. The QA committee will determine when the may be discontinued Corrective Action will be monitored DON or Designee	te. to R her re and hitial to e. An s were ds e s. e. , 2015 Staff he al gs were dom e en nthly. are PI audits		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa provide mouthwash		F3	312			
	assistant (NA)-G was morning cares. At offer R99 oral cares -At 7:26 a.m. R99 was room for breakfastAt 8:50 a.m. NA-H breakfast table to the	vas assisted to the dining					
	were to be complet	a.m. NA-H stated oral cares ed before breakfast. She t offered oral cares after the					
	not offered or provide	a.m. NA-G verified she had ded R99 oral cares and stated ovided oral cares during					
		a.m. registered nurse (RN)-A I have completed oral cares as are plan.					
	R23 was not provid as directed by the c	ed oral cares or perineal cares care plan.					
	R23 had dementia, was incontinent of the	S dated 9/29/15, indicated severe cognitive impairment, pladder and required required h all activities of daily living					

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		245368	B. WING			11/(	06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 923 HALE LAKE POINT GRAND RAPIDS, MN	E		, <b>= 0.10</b>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD ICED TO THE APPROPP EFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	_	F3	12			
	no teeth and directe twice a day. The pl provide perineal ca	red 1/7/15, indicated R23 had ed staff to provide oral cares an also directed staff to res after each incontinent ze protective skin creams.					
	provide R23 with mobserved to be total complete the task at communicate.  -At 6:20 a.m. NA-H assisted NA-G with -At 6:30 a.m. R23 was wheelchair via a faracteristic -At 8:57 a.m. NA-H room to her room. transferred R23 to -At 9:00 a.m. NA-H check R23's inconting was observed NAs removed the bootserved to cleans	vas transferred from the bed to fully body mechanical lift. vas wheeled to the breakfast wheeled R23 from the dining NA-G and NA-I assisted R23 bed. and NA-I were observed to inent brief. R23's incontinent saturated with urine. Both wrief and applied a new one. At observations were the NAs e R23's perineal area following tode nor were the NAs					
	were to be complet perineal cares were incontinent episode	a.m. NA-H stated oral cares ed before the meal and e to be provided after an e. NA-H verified she had not cares or perineal cares as					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED
		245368	B. WING _		11,	/06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	Continued From pa	_	F 31	12		
		a.m. NA-G verified she had ral cares during morning				
	were to have been cares as directed b	a.m. RN-A stated oral cares completed during morning y the care plan. She also es were to be completed ntinent episode.				
	staff to provide oral lips and oral tissues	olicy dated 10/2010, directed cares to ensure the residents is were moist, to cleanse and it's mouth and to prevent outh.				
F 318 SS=E	the staff to provide incontinent episode	EASE/PREVENT DECREASE	F 31	18		12/15/15
	resident, the facility with a limited range appropriate treatme	orehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion.				
	This REQUIREME	NT is not met as evidenced				

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	PROVIDER OR SUPPLIER		g	STREET ADDRESS, CITY, STATE, ZIP CODE 123 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	by: Based on observareview, the facility of motion services in maintain range of residents (R23, R7 had limitations in rational final fina	tion, interview and document failed to provide range of order to prevent a decrease or motion (ROM) ability for 3 of 3 2, R122) in the sample who ange of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.  The range of motion services to so in range of motion.	F 318	Corrective Action- R 23, R 72, ar have been reassessed for their F needs. Their care plans have be updated to reflect their current needs. Their care plans have be updated to reflect their current needs. Their care plans have be updated swith ROM have the potential to be effected deficient practice. An audit of res ROM needs was completed and plans have been updated as app PT/OT is involved in resident RO as appropriate.  Date of Completion: December Recurrence will be prevented by: members have been educated on need to provide the appropriate F residents. All staff educational m were held on November 30, 2015 Random ROM/Care Plan audits weekly for one month and then m The Nurse Managers and/or DOI responsible to complete these au The QAPI committee will determit the audits may be discontinued. Corrective Action will be monitore DON or Designee	ROM en eeds. other I needs by this sident care ropriate. M needs 15, 2015 Staff n the ROM to leetings by will be then honthly. N are lidits. ine when	
	R23 did not receive minimize limitation:  R23's quarterly Mir 9/29/15, indicated (loss of ability to ur severe cognitive in one side of the uppassistance with all annual MDS dated having limited ROM body.  R23's Nursing Assindicated R23 had of her upper extremer lower extremition R23's care plan dadependent upon st living and directed	nimum Data Set (MDS) dated R23 had dementia, aphasia inderstand or express speech), inpairment, had limited ROM on per body and required total staff activities of daily living. R23's 6/29/15, also identified R23 as M on one side of her upper essment dated 9/28/15, limitations in ROM on one side nity and had no limitations in es.		deficient practice. An audit of res ROM needs was completed and plans have been updated as app PT/OT is involved in resident RO as appropriate.  Date of Completion: December Recurrence will be prevented by: members have been educated on need to provide the appropriate Fresidents. All staff educational mwere held on November 30, 2015 Random ROM/Care Plan audits word completed daily for 2 weeks and weekly for one month and then man The Nurse Managers and/or DOM responsible to complete these audits may be discontinued. Corrective Action will be monitored.	sident care ropriate. M needs 15, 2015 Staff n the ROM to reetings 5. will be then roonthly. N are redits. In when	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3	B) DATE SURVEY COMPLETED
		245368	B. WING			11/06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIAT	
F 318	R23's nursing assis program directed the passive ROM exerce to the upper and low repetitions each. To maintained the ability hold her daughters.  Review of the Rester documentation for the documentation for the documentation limbs received the Interest of the Review R23's clinical notes related to R25 her restorative programmer. The documentation limbs received the Interest of th	tant Point of Care (POC) re activity staff to provide R23 rises which included stretching wer extremities for ten he goal was to ensure R23 ty to sit in her wheelchair and hand during visits.  Prative Passive ROM Detober 2015, indicated R23 or 20 minutes six days a week. did not identify which joints or ROM.  all record lacked progress all's progress or regression of ram.  a.m. nursing assistant (NA)-F rerved to transfer R23 from air via a full body mechanical re observed to be in a closed on. R23 was not observed to her legs independently revation.  was observed to apply rectors to R23's arms. R23 application. NA-H applied a 23's shoulders and elbows to extend to assist with the weater. R23's hands remained during the application of the	F3	818		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		COMPLETED		
		245368	B. WING _		11	/06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
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F 318	On 11/4/15, at 7:53 feed R23 the break observed to move I totally dependent u -At 9:15 a.m. NA-G transfer R23 from t mechanical lift. On provided R23 with I were observed slig clamped together a be in a pointed dow	a.m. NA-F was observed to fast meal. R23 was not her upper extremities and was pon the staff for meal. and NA-F were observed to he chair to bed via the ince in bed, NA-G and NA-F incontinence cares. R23's legs had bent at the knees and and her feet were observed to unward position (foot drop).	F 3 <sup>-</sup>	18		
	stated R23 receive week during activiti staff completed arm 20 minutes each da arms and legs had	p.m. activity aide (AA)-A d passive ROM six days a es. AA-A stated the activity n and leg repetitions for about ay. AA-A also stated R23's been "tight" but were much med stronger after receiving ROM.				
	provide morning ca to open R23's left h R23's left shoulder left elbow did not e also able to open F however, R23's find degrees. R23's right shoulder was able cleansing. NA-G st were unable to be the -At 6:15 a.m. NA-H with cares. NA-H a R23's lower body of	a.m. NA-G was observed to trees for R23. NA-G was able and and wash it and move slightly to wash under it. The extend during cares. NA-G was a23's right hand to wash, gers did not extend past 90 at elbow did not extend and the to be moved to allow for ated R23's upper extremities fully extended.  entered the room to assist and NA-G both completed ares. R23's feet remained in a ssisted with donning socks.				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
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F 318	R23's legs were ob slightly bent at the perineal cares and stated R23 had alw completing cares. at the facility for the always had limitation	age 49 served to remain together and knees as the NAs completed applied R23's pants. NA-H vays been "tight" when NA-H stated she had worked a past two years and R23 had ons in her ability to move. ad not changed in the past	F 3	8		
	stated she completed complete bedside in dependent resident coding was transor assessment which assessment which and size a.m. RN-D ROM for R23 while R23 displayed bilated limitations in range elbows, hands and and and and and and are similations in ROM extremities. At the shad completed R23 assessment, and shad limitations on costated she completed size as a size and a s	a.m. registered nurse (RN)-D red the MDS but did not ROM assessments on red. RN-D stated all MDS red from the Nursing was completed by the RN-A red was observed to complete R23 was in bed. RN-D stated real upper and lower of motion in the shoulders, hips, knees and feet. The verified the MDS was not red it did not identify R23's red in both upper and lower same time, RN-A verified she red it did not identify R23's red in both upper and lower red it did not identify R23's red in both upper and lower red it did not identify R23's red in both upper and lower red it did not identify R23's red in both upper and lower red it did not identify R23 only one side of her body. RN-A red the ROM assessment at dependent residents.				
	perform passive R0 R23 was seated in observed to gently and shoulders. AA	6 a.m. AA-A was observed to OM exercises for R23 while the wheelchair. AA-A was move R23's hands, elbows -A completed repetitive th joint. She was able to fully				

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F 318	shoulder did not full was able to be open observed to be strashoulder were move be fully extendedAt 11:37 a.m. AA-A to do leg exercises hip and knees while At no time was AA-passive ROM to R2-At 11:43 a.m. AA-A On 11/5/15, at 11:48 RN had trained her She stated she had for greater than a yelimitations in ROM a changed in the passidid she complete ROM 11/5/15, at 11:50 observed AA-A perfinot completed any to AA-A's ROM programmer and any concerns abilities were all new RN-C was in charge and any concerns yellow documentation.  On 11/5/15, at 2:30 on 11/5/15,	and. The left elbow and ly extend. R23's right hand hed, but the fingers were not ightened. The elbow and ed, but were not observed to A knelt on the floor and began for R23. AA-A moved R23's e she was seated in the chair. A observed to attempt to do 3's feet. A completed the cares.  5 a.m. AA-A stated a former to complete ROM exercises. I been assisting R23 with ROM ear. AA-A verified R23 had ability but they had not tyear. She verified at no time	F 3	18			

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F 318	members met on a restorative program attended the restor feedback related to from the activity sta documentation relaprograming completed restorat residents including for RN-C to locate related to R23's recurrent medical recevaluations.  On 11/6/15, at 8:30 completed the MDS onto the nursing ur assessments. She the MDS according documentation. RN Assessment completen the assessment completen the assessment when needed to che documentation cor RN-D was not experienced to the complete to the	age 51 I monthly basis to review the in. RN-C stated AA-A had not rative meetings nor provided the residents' receiving ROM aff. RN-C stated any ated to the restorative reted by AA-A would be up to RN-A verified she had not rive reviews on AA-A's R23. The surveyor requested any therapy documentation storative program as the rord did not contain therapy  I a.m. RN-C verified RN-D assessment but did not go not to the Nursing Assessment are to the Nursing Assessment and are to the Nursing leted on 9/28/15, would have rent used for the completion of dated 9/29/15. RN-C stated any went on to the nursing assessed a resident only reck areas of concern if the atraindicated itself. She stated rected to complete ROM for mpletion of an MDS.  I a.m. RN-D reported she had therapy evaluations. The evaluation dated 3/27/13, bilateral limitations in ROM in resincluding hips, knees and passive ROM program was me R23 was identified with in her shoulders, arms and	F 31	8		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 318	hands. RN-D also communication date and RN-A in which longer able to move On 11/6/15, at 8:45 be receiving ROM t further foot dropAt 8:47 a.m. RN-D several long term of R23's ROM had note - At 9:00 a.m. RN-C program policy direct monitor the resident hey were receiving maintain/prevent further services annual MDS was diagnosed with had severe cognitive to maintain to the receive minimize limitations.	provided email ed 10/16/14, between herself RN-A indicated R23 was no e her feet.  a.m. RN-C stated R23 should o her feet in order to prevent  stated she had interviewed taff members who all indicated t changed in the past year. C stated the facility restorative cted the unit mangers to ts' ROM program to ensure the necessary services to	F3	318	BEHOLINOTY		
	utilized a wheelchai staff and an E-Z me	red 12/19/14, indicated R72 ir and was transferred with two echanical lift. The care plan did ig restorative program.					
	program note dated had late entry next described R72 as h lower extremities in	rd included a restorative I 9/9/15, written by RN-B and to the date. The note aving limitations to bilateral both knees. The note indicate x and extend, invert and avert					

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F 318	ankles, hips and all extremities. The no for decline in ROM, and required staff a destinations. The fuprogram would be sidecline and R72 wo quarter.  R72's medical reconinitiated a new restor NAs to complete. The passive range of modirected staff to proflexion and extensive elbows, wrist, finger toes daily.  On 11/06/15, at 10:seated in a wheelch straight out and restor not on the foot peda on 11/6/15, at 10:2 (LPN)-D stated R72 (LPN)-D stated R72 R72 no long wheelch himself like he used assist for all position R72's monthly rehat indicated PROM was september on 9/6/1	other joints of the lower te indicated R72 was at risk was wheelchair dependent assist to propel to all urther indicated a restorative set up in order to prevent any ould be re-evaluated next ord indicated on 9/5/15, RN-B prative program for R72 for the he program consisted of otion six times per week and vide abduction, adduction, on to bilateral shoulders, rs, hips, knees, ankles and 15 a.m. R72 was observed hair with both legs extended ting on top of the foot pedals, als.	F3	18		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
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F 318	On 11/6/15, at 1:03 was completed in Finursing staff to concompleted. RN-B conly signed off as k RN-B verified R72' documentation whi provided to R72.  R122 did not receive minimize limitations directed by the care minimize limitations directed by the care R122 was diagnos on one side of the also indicated R12: ROM on one side of required extensive daily living.  R122's Activities of 2/23/15, indicated assisted living and had a stroke many the hemiparesis or indicated R122 was (PT) and occupation	R p.m. RN-B stated a task form R72's medical record to direct applete and sign off when confirmed R72's PROM was being completed only twice. It is record had no other character and the	F 31	8		
	refer to nursing res program specifics. dated 3/25/15, indic	dated 11/6/15, directed staff to storative documentation for R122's restorative program cated R122 was to receive es to the upper extremities.				

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F 318	R122's restorative prindicated R122 was training to the left h	ge 55 program dated 5/14/15, s to receive splint / brace and and gentle stretching of rams were to be provided six	F 3	18		
	bed. R122 stated sistervices six days a getting the services Mon-Wed. (11/2/15 rehab. However, Richosen to attend a she had attended the rehab services. R1 department was to and that was not have weeks, the department only three days a wiclosed the doors ar	a.m. R122 was observed in he was to receive rehab week and she had not been at R122 stated this week r-11/4/15) she had not received r122 stated yesterday she had Christian activity and being the activity, she did not get r122 also stated the rehab r122 be open seven days a week r122 stated some r123 stated some r124 stated some r125 stated some r126 stated some r126 stated some r127 stated some r128 stated some r129 stated stated stated stated some r129 stated some r129 stated sta				
	medication aide (TI received rehab servestorative plan due rehab department a floor. Rehab aid/TI happened, the reha	5 p.m. the rehab/ trained MA)-verified R122 had not vices as directed on her to being pulled from the and having to work on the MA-A stated when that ab doors were closed and no I for any of the residents.				
	verified R122's care and stated R122 wa	0 a.m. RN-B reviewed and e plan and rehab directives as to receive the services six irected. RN-B verified R122				

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F 318	to the rehab staff be department.  The undated, Resto	ge 56 hab services as directed due eing pulled from the rehab erative Care Policy indicated irected toward assisting each	F 31	8		
	resident to achieve level of self-care the motion and ambula the residents' would admission by PT/O determine goals and	and maintain their highest rough positioning, range of tion. The policy also indicated the assessed at time of T whereby PT/OT would delevel of restorative care m PT/OT therapy services.				
F 323 SS=D	staff to provide care individual care plan 483.25(h) FREE OF HAZARDS/SUPER  The facility must en environment remain	FACCIDENT VISION/DEVICES sure that the resident as as free of accident hazards	F 32	3		12/15/15
	adequate supervision prevent accidents.  This REQUIREMENT by: Based on observator review, the facility for supervision to ensure resident (R148) who	each resident receives on and assistance devices to on, interview and document alled to provide adequate re the safety for 1 of 1 or displayed wandering sulted in falls, resident to		Corrective Action- R 148 has bee assessed for safety on the unit and interventions have been put into plakeep her safe. Her care plan has bupdated. Resident is being closely	ace to been	

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F 323	resident physical all touching.  Findings include:  R148's quarterly M 9/25/15, indicated for dementia, anxiety of seizure disorder. The had severe cognitive physical aggression wandering behavior assessment period R148 required externor of daily living and reassistance of one seizure disorder.  R148's The Activitie Assessment (CAA) R148 was able to a any type of assistive falls.  R148's Cognition CR148 was diagnosed risk for further cognitive for further co	tercations or inappropriate  Inimum Data Set (MDS) dated R148 was diagnosed with disorder, depression and a ne MDS also indicated R148 we impairment and displayed in towards others 1-3 days and rs 4-6 days of the MDS.  The MDS also indicated nsive assistance with actives equired supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.  The MDS also indicated inside a supervision to limited staff while ambulating.	F 323	monitored by unit staff and they as separating her from other resident necessary. Corrective Action as it applies to desidents. All residents on this unthe potential to be affected by the behaviors of resident 148. Staff in have been educated on the need intervene and separate residents. members have also been educated need to attempt distraction technic when R148 is wandering. The resident of the need to monitor resident separate her from other residents necessary.  Date of Completion: December 1 Recurrence will be prevented by: members have been educated on need to intervene and separate resto prevent behaviors. They have been educated to use distraction technique when R148 is wandering staff educational meetings were held November 30, 2015. Random observational audits will be completed aily for 2 weeks and then weekly month and then monthly. The Numanagers/DON are responsible for audits. The QAPI committee will determine when the audits may be discontinued. Corrective Action will be monitored DON or Designee.	ther it have nembers to Staff on the ques sidents ed to at and when 5, 2015 Staff the sidents elso on the sidents elso g. All eld on eted for one arse or the	

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F 323		ners and to intervene if	F 3:	23		
	was at risk for falls nursing unit and wa from harm. The ca intervene and sepa safety concerns we	ated 12/26/14, indicated R148, wandered throughout the as unable to remove herself are plan directed staff to rate resident from harm when are identified, to ensure R148 R145 and to keep the				
	from 1:00 p.m. to 8 a.m. to 4:30 p.m., o 3:30 p.m., on 11/5/ and on 11/6/15, fro was observed to pa care unit. R148 wa out of other resider may or may not hav observed to bump	survey conducted on 11/2/15, :00 p.m., on 11/3/15, from 8:00 on 11/4/15, from 7:00 a.m. to 15, from 6:00 a.m. to 2:30 p.m. m 8:00 a.m. to 1:00 p.m. R148 ace non stop on the memory as observed to wander in and at rooms, pick up items that we belonged to her and was into furniture and other that also resided on the unit.				
	3:48 to 4:20 p.m. Dobserved to ambulatione shoe which was She carried the shoagain. R148 walked and walked into a rof the unit. At not to the unit observed to -At 3:50 p.m. R108	began wandering with R148. did not speak to each other as				

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F 323	chair in the dining a slightly as she continued. R108. Shortly there room 420 and exite -At 4:04 p.m. R108 residents continued directions.  On 11/4/15, from 7: was observed to ha from a nursing assi (NA)-I, NA-H and NR148 and assisting observed to be very walk with her eyes observed to guide fenvironment to ens-At 9:27 a.m. NA-H one assistance bed during a grand mal extra tired and wea  R148's Progress Norevealed the following a grand mal extra tired and wea  R148's Progress Norevealed the following a grand mal extra tired and wea  R148's Progress Norevealed the following a grand mal extra tired and wea  R148's Progress Norevealed the following a grand mal extra tired and wea  R148's Progress Norevealed the following a grand mal extra tired and wea  R148's Progress Norevealed the following a grand mal extra tired and wea	was observed to bump into a trea. She moved the chair inued to walk the unit with after, both residents entered d it at 3:52 p.m. left R148 and the two I to walk in separate  04 a.m. to 9:30 a.m. R148 are one on one observations stant (NA). Nursing assistant A-F took turns walking with with her meal. R148 was a sleepy and at times would closed. The NA's were R148 around obstacles in her ure her safety. Stated R148 required one on ause she had sustained a fall seizure at 6:00 a.m. and was k following the seizure activity.  In the seizure activity.  In the seizure activity. It is a seizure at I and the seizure at I and the seizure activity. It is a seizure at I and the seizure activity. It is a seizure at I and the seizure activity. It is a seizure at I and I	F3	23			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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F 323	resident in a comm resident with deme times on the hand. 3/6/15, directed the -On 3/17/15, at 3:4. Rivers Community resident with deme down R148's pants separated the resident intervene as neces - On 3/29/15, at 8:1 R145's room holdir was standing in frompants down with his intervened and rem The Incident Reports aff to monitor R14 - On 4/3/15, at 2:30 R145's room (male R148 was found serecliner and partiall hand resting on hel Report directed the R145's door and had - On 4/16/15, at 2:30 unidentified resider hit her in the arm. 4/16/15, directed the residents On 4/21/15, at 5:30	B p.m. R148 was up to another on area. R22 (a female ntia)slapped R148 several. The Incident Report dated e staff to redirect the residents.  5 p.m. R148 was found in the seated next to R145 (a male ntia). R145 had his hand. The staff members lents and directed the staff to R148's whereabouts and sary.  2 p.m. R148 was found in neg hands with R145. R148 nt of R145 and he had his penis out. Staff members noved R148 from R145's room. It dated 3/29/15, directed the 48's whereabouts.  9 p.m. R148 was found in resident with dementia). Pated partially on the arm of a yon R145's lap. R145 had his rupper thigh. The Incident estaff to place a fall mat inside	F3	23			

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F 323	staff to let go of R1 approached R55, h causing her to stum. The Incident Repors staff to monitor for residents away from - On 4/21/15, at 11: with dementia) enterest from a wheelch seated on the bed. grabbed R148's brown Staff redirected the report dated 4/21/1 the residents close - On 4/21/15, at 11: the head with a clost dated 4/21/15, direct mood changes.  - On 4/22/15, at 10 another room and thappened, R148 felincident Report date to observe resident if tired.  - On 7/3/15, at 10:2 unidentified resider sustained a bruise Report dated 7/3/15 changed the call lig material.  - On 7/5/15, At 1:08 R99's (a female residence in the call ligonaterial).	nd. He was directed by the 48 but refused. As staff the yanked on R148's hand on the him. The thick the bruising and keep the	F3	323			

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
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F 323	R99 hit R148 on the Report dated 7/5/13 the residents. The but she opened it a - On 7/8/15, at 10:1 the left upper arm. R63 punched R148 members separate Report dated 7/8/13 keep the other resident with R148 and hit hincident Report date to attempt to keep - On 7/14/15, at 10 another resident with R148 and hit hincident Report date to attempt to keep - On 7/14/15, at 10 another resident with grabbed R148's and then grabbed the u too would not let go Incident report date attempt to separate when needed.  - On 7/19/15, at 1:2 right should by an uprogress note directed the staff to appropriate.  - On 8/3/15, at 1:51	e right shoulder. The Incident 5, indicated the staff separated of offered to shut R99's door, gain.  O p.m. R63 grabbed R148 in Before staff could intervene in the left arm. The staff of the residents. The Incident 5, directed the staff to try to dents away from R148.  C30 a.m. R148 was walking and entered room 415-2. The in the room became upset her in the lower back. The ed 7/12/15, directed the staff the residents separated.  C30 a.m. R148 walked by the nen the unidentified resident and would not let go. R148 indentified resident. The ed 7/14/15, directed the staff to be the residents and to intervene ed 7/14/15, directed the staff to be the residents. The counterproperty of the staff to monitor for ent Report dated 7/19/15, in separate and intervene as p.m. R148 entered room 419	F 32	23		
	of the room. R148	et an unidentified resident out grabbed the unidentified eve and would not let go. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/06/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	- On 8/16/15, at 8:3 with dementia) grathit her in the left ey R148 away from R9 - On 8/30/15, at 3:4 on her forehead/hadoor and hitting her lincident report date be more aware of Fopening and closing - On 9/4/15, at 7:50 a crashing noise in R148 seated on the not indicate any typ Report directed the alertness while ambiguity and the standing over an unresident was in bed grabbed R148's wr The residents were Report dated 9/11/1 separate residents - On 9/24/15, at 2:4 on the upper left chwas noted. The lindirected the staff to - On 9/24/15, at 9:4 serenity room on the and side table next the Incident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the staff to - On 9/24/15, at 9:4 serenity room on the lincident report of the	arated the residents.  30 p.m. R93 (a female resident obed R148's arm strongly and e/face area. The staff moved 93.  45 p.m. R148 received a bump irline from walking into a glass r head on the door. The ed 8/30/15, directed the staff to R148's proximity to doors g.  40 a.m. the staff members heard R148's room. The staff found e floor. The progress Note did be of injury. The Incident e staff to watch for residents	F3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		245368	B. WING			11/06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
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F 323	room 416 on the flof from a mechanical Incident Repot date to ensure the mech place when not in u - On 10/25/15, at 8: walking around the resident rooms, but objects. At this timunidentified resident resident's feet, causinjuries noted. The 10/25/15, directed the unsafe situations if - On 10/29/15, at 2: on R187's (female R187 attempted to intervene. The Incident to monitor and seption of the door with th	1:39 a.m. R148 was found in our holding a weighted blanket lift. No injury was noted. The ed 10/17/15, directed the staff ranical lift was locked and in use.  33 p.m. R148 was observed unit, in and out of other mping into furniture and other e she walked by an at and tripped over the sing her to fall to the floor. No Incident Report dated the staff to remove R148 from able.  10 p.m. R148 was observed resident with dementia) room. hit R148 but staff were able to dent Report directed the staff arate the residents as able.  30 a.m. the staff heard a noise 48 may have bumped her thile walking out of the room.  5.5 centimeter (cm) by 2.0 cm ehead. No incident report was	F3	23		

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245368	B. WING			11/	06/2015
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 23 HALE LAKE POINTE BRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	On 11/4/15, at 12:4 nurse (LPN)-I state Lakes Neighborhood altercations with oth when that happene separated. LPN-I soccasionally fall or stated R148 did not precautions when a mat by her bed and bed. LPN-I stated if at each other, the rough stated she was involved with reside had not observed a continuon the unit. AA-A st disrupted other residence as the continuon the unit. AA-A st disrupted other residence as the continuon the unit. AA-A st disrupted other residence as the continuon the unit. AA-A st disrupted other residence as the continuon the unit. AA-A st disrupted other residence as the continuon the unit. AA-A st disrupted other residence as the continuon that are the continuous transport of the continuous trans	Is p.m. licensed practical d R148 wandered around the od and at times would have her residents. She stated d, the residents were stated R148 would also sit on the floor by herself. She thave any specific fall ambulating, but utilized a fall a parameter mattress on the she noticed residents hitting esidents would be separated. It is aware of R148 being ent to resident altercations, but my of the alleged altercations.  It p.m. activity aide (AA)-A coustly wandered and paced ated she not feel R148 dents but confirmed R148 dover other residents. AA-A sticed R148 wandering she er R148 in a one to one activity.  In p.m. NA-H stated R148 he stated R148 did not seem to he other residents nor did the		323			
	stated occasionally at each other and w separated the resid On 11/4/15, at 1:40	p.m. licensed social worker					
	any concerns relate	e had not been made aware of ed to resident to resident kes Neighborhood. She					

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		245368	B. WING			11/	06/2015
	PROVIDER OR SUPPLIER			92	REET ADDRESS, CITY, STATE, ZIP CODE 13 HALE LAKE POINTE RAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	confirmed at the tin two residents with of who wandered daily rooms. She also staggressive behavior residents. She veri was busy and had at to resident altercati had not completed interventions to incomplete the control of the cont	the of survey, the facility had dementia (R148 and R108) or in and out of other residents ated R187 had displayed are towards staff and other fied the Lakes Neighborhood an increased risk for resident ons. She verified the facility any type of formal rease supervision on the od.  6 p.m. registered nurse latercations involving R148 residents with dementia ents were just to be observed the stated R148's behaviors are the doors between the two seems which decreased the election of the male residents. She ad not put any other the topic to increase the supervision aborhood.  4 p.m. LSW-A stated the eased staffing or supervision aborhood in an attempt to or resident altercations. She intervention was to close the		323			
	(DON) stated the fa members education	7 p.m. the director of nurses acility had provided the staff a regarding approaching entia. She stated the activity					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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F 323	received training so residents as needed	n staff members had also they could assist with the d.	F 32	23		
	there were concern other staff members the Lakes unit to as there had been no i change in staffing s	6 p.m. the DON stated when s on the Lakes unit, she or s, when available, had gone to esist. The DON confirmed ncrease in supervision or tructure on the Lakes unit nt to resident altercations as				
F 325 SS=D	with dementia was provided.	taff supervision of patients requested and none was N NUTRITION STATUS DABLE	F 32	25		12/15/15
	resident - (1) Maintains accept status, such as bod unless the resident' demonstrates that the state of the s	otable parameters of nutritional by weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a				
	by: Based on observat	NT is not met as evidenced ion, interview and document ailed to ensure a resident with		Corrective Action- R 203 has b assessed related to supplemen		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11/	06/2015	
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F 325		_	F 32				
	supplementation as and preference in c	nal decline received nutritional ecording to the assessed need order to minimize weight loss sidents reviewed for nutrition.		care plan has been updated to rorder. The TAR has been correupdated to reflect the orders. Corrective Action as it applies to residents- all residents on nutritisupplements have the potential	ctly o other onal		
	Findings include:			effected by this deficient practic Residents have been reviewed interviewed for preference. The	e. and		
	R203's admission Minimum Data Set (MDS) dated 9/4/15, indicated R203 had dementia and a severe cognitive impairment. The MDS also indicated R203 weighed 149 pounds and required supervision from staff while eating.  R203's medical record revealed the following: -on 8/29/15, R203 weighed 149 pounds (lbs.) -on 9/12/15, weighed 145 lbson 10/25/15, weighed 140 lbson 11/2/15, 137 lbs.  R203's Dietician Progress note dated 10/27/15, indicated R203 had a weight loss and was started on 4-6 ounce house or house juice supplementation three times a day between meals.			plans have been updated to refl and preferences. The TARs of residents reflect their needs. Date of Completion: December Recurrence will be prevented by members have been educated of	ect needs these 15, 2015 v: Staff on		
				nutritional supplements and pre Random MAR/TAR nutritional si audits will be completed daily for and then weekly for one month monthly. All staff educational me were held on November 30, 201 Nurse Managers and/or DON at	upplement r 2 weeks and then eetings 5. The		
				responsible for the audits. The committee will determine when may be discontinued Corrective Action will be monitor DON or Designee	the audits		
	indicated R203 was	order dated 10/27/15, s started on a house e supplement 4-6 ounces three en meals.					
	completed by regis	ress noted dated 11/3/15, and tered nurse (RN)-A indicated almost 10 pounds less than					

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F 325	alerted on that date house supplement with the hope R203	age 69 t. The dietitian had been e and R203 was started on a three times a day on 10/27/15, b's weight returned to baseline e supplement was never	F3	25		
	was observed in the R203 consumed select hot chocolate and the R203 consumed select the R203 consumer to the R203	:30 a.m. until 8:30 a.m. R203 e dining room eating breakfast. everal bites of toast, a cup of three ounces of apple juice. Ty busy talking to herself and rested in eating.				
	(LPN)-B stated she receive a nutritional R203's Treatment A which would have i R203 a supplement indicated R203 was provide R203 a nut	a.m. licensed practical nurse was not aware R203 was to I supplement. LPN-A reviewed Administration Record (TAR) dentified the need to provide t, stated the TAR had not so to receive and no directive to critional supplement. LPN-A provided R203 a supplement he day shift.				
	dietitian had writter supplement on 10/2	5 a.m. RN-A verified the nan order for R203's 27/15, however stated it was use the order was in-putted wrong.				
	Recommendations recommendations	utrition Therapy (MNT) , undated, indicated MNT from the registered chnician would be implemented				

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F 325 F 329 SS=D	documented. Any re nursing's attention of be forwarded in writ	nplementation would be ecommendations, which need or a physician's order, would ting to the nursing staff. EGIMEN IS FREE FROM	F 329			12/15/15
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from  An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs therapy is necessar as diagnosed and crecord; and residen drugs receive gradubehavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug by to treat a specific condition documented in the clinical that who use antipsychotic used dose reductions, and tions, unless clinically an effort to discontinue these				
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview and document illed to ensure a ep assessment and sleep		Corrective Action- R 203 has been assessed and indications for use o Trazadone have been established.	f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 329	Continued From pa	ige 71	F 329				
	non- pharmacologic to the administration	npleted and failed to identify cal interventions for sleep prior n of a hypnotic (used for sidents (R203) reviewed for cations.		pharmacist has reviewed the med The care plan has been updated the indication for use. Non-pharmacological intervention been added to the care plan and Corrective Action as it applies to desidents all residents receiving	to reflect s have MAR.		
	Findings Include:			psychotropic medications have th potential to be effected by this depractice. The resident □s medications	ficient		
	R203's admission Minimum Data Set MDS dated 9/4/15, indicated R203 had dementia with severe cognitive impairment and required extensive staff assist for mobility, dressing and toileting. Section D0200 of the MDS did not indicate R203 had any trouble falling or staying asleep or sleeping too much.  R203's care plan dated 9/17/15, lacked identification of insomnia or monitoring of individualized insomnia symptoms. In addition, the care plan lacked evidence that non-pharmacological approaches were tried before the administration of the medication. R203's Nursing Assistant (NA) care plan did not include any non-pharmacological interventions to promote sleep.			have been reviewed and indication use are in place. The care plans residents have been updated to retheir needs. Non-pharmacological interventions have been added to MAR and Care Plans as appropriate of Completion: December 1 Recurrence will be prevented by:	ns for of these eflect al the ate. 5, 2015 Staff		
				members have been educated or psychotropic medication indication use. The use of non-pharmacolo interventions was addressed at the staff educational meetings which held on November 30, 2015. Ramar MAR audits related to psychotrop medications use and non-pharma interventions will be completed daweeks and then weekly for one methen monthly. The Nurse Manager	ns for gical ee all were andom ic cological aily for 2 onth and ers		
	directed staff to add	sician's orders dated 10/12/15, minister Trazodone HCL tablet bed time for insomnia.		and/or DON will be responsible.  QAPI committee will determine w audits may be discontinued.  Corrective Action will be monitore DON or Designee	hen the		
	bed, asleep. -At 6:00 a.m. NA-A	a.m. R203 was observed in and NA-B were observed to bed into the wheelchair, wheel					

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F 329	cup of coffee.	ge 72 room and provide R203 with a was observed eating	F 3	29			
	verified R203 was of sleeping. RN-A state sleep study assess after the medication stated there was not note related to the creactions from the precord. In addition, plan lacked any indireceived medication pharmalogical inter-	3 a.m. registered nurse (RN) on Trazadone due to not led she did not complete a ment prior the initiation of or n was administered. RN-A also documentation or summary effectiveness or adverse medication in R203's medical RN-A verified R203's care ication R203 had insomnia, n to induce sleep, non ventions to be attempted or f adverse reactions to monitor					
F 371 SS=F	requested however 483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food fro considered satisfact authorities; and	om sources approved or story by Federal, State or local distribute and serve food	F 3	71		12/15/15	

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F 371	This REQUIREMEI by: Based on observat review, the facility f procedures were in maintain adequate pasteurized hard bothe resident salad cimplement appropriprocedures related probe in between for practices had the presidents in the fact the kitchen and / or Findings include:  Norway dining room  On 11/2/15, at 5:00 was observed in the salad cart. The carl large bowl of lettuck which contained bocarrots, pickled becseds. The cart did the salad toppings -At 5:03 p.m. NA-K from table to table a dining room if they them to build a salat the surveyor approatemperature of the eggs were found to	ion, interview and document ailed to ensure appropriate applemented in order to holding temperatures of biled eggs when served from eart. The facility also failed to late food temperature to cleaning the thermometer bod items temped. These otential to affect all 111 lility who received food from salad cart.	F 37	Corrective Action- The Lakes kitch has been cleaned. Food tempera are now being monitored for safe handling. Corrective Action as it applies to cresidents- All residents have the to be effected by the condition of kitchenettes. All kitchenettes have cleaned and food temperatures a being monitored. The kitchenette cleaning policy and the food temperatures have been reviewed and as appropriate. Date of Completion: December 1 Recurrence will be prevented by: members have been educated or need to have clean kitchenettes a monitor food temperatures to ass food handling. All staff education meetings were held on November 2015. Random kitchen and food temperature audits will be complet for 2 weeks and then weekly for comonth and then monthly. The Normangers and/or DON will be resonant the audits may be discontinued. Corrective Action will be monitore DON or Designee	other potential the e been re now erature revised 5, 2015 Staff of the nd to ure safe al considerated daily ne urse ponsible.	

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F 371	neighborhood betwithe salad cart contable kept cool when so did not have a systeritems remained cool eggs from the salad.  Wolf/Moose Lodge  On 11/2/15, at 5:20  Moose / Wolf dining wheeling a salad canursing staff stated all the residents in tocart was observed to lettuce and several boiled pasteurized beets, cucumbers at time, cook (C)-A cheggs which measur manager stated state of the refrigerator ethe Lodge/Wolf dinion on 11/4/15, at 11:50 wheeling a salad cand several other solarger bowel that was the ice was somether the same contable to the salad cand several other solarger bowel that was the ice was somether the same contable to the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other solarger bowel that was the ice was somether the salad cand several other salad c	d arrived on the Norway een 4:00 - 4:15. NA-K verified kined boiled eggs which should be erved and stated the facility em in place to ensure the bl. NA-K removed the boiled d cart.  Dining Room:  p.m. the nursing staff in the g room were observed art into the kitchen. The they had just finished offering he dining room a salad. The to contain a large bowl of smaller bowls that contained eggs, cheese, carrots, pickled and sunflower seeds. At this ecked the temperature of the ted 48 degrees F. The dietary ff had taken the food items out arlier and wheeled them on to	F3	71			
	The undated Storag	ge of Good policy directed staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING _		11	/06/2015	
	PROVIDER OR SUPPLIER  VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		, • • • • • • • • • • • • • • • • • • •	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 371	to ensure cold food degrees and an int kept in all refrigera.  Woods Dining roor  On 11/04/2015, at to pick up the food kitchen for the Wood DA-A was observe into the steam table thermometer probed DA-A inserted the without cleaning the same probe into the degrees) Fahrenhe wiped the probe of proceeded to chec (195 F) and the sw DA-A rinsed the the running water at the paper towel. DA-A (178 F), followed w F). DA-A wiped the	d was maintained at 32-40 ernal thermometer was to be tors and freezers.	F 37	,			
	and wiped the prob proceeded to temp rinsed the thermon and wiped off the p checked the temp cheese (40 F). DA the thermometer p	the off with a paper towel then the gravy (187 F). DA-A neter off under running water probe with a paper towel. DA-A of the lettuce (38 F) and -A was not observed to clean robe between foods.  57 p.m. DA-A stated, "I am a wipes to clean the eafter each food, and I did not					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
		245368	B. WING		11//	06/2015
	PROVIDER OR SUPPLIER  VILLAGE		9	TREET ADDRESS, CITY, STATE, ZIP CODE 123 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa do that."	ge 76	F 371			
F 428 SS=D	sanitizing wipes sho cleanse the thermo food item. However aware some of the proper probe cleans have used alcohol wipes came in.  The undated, Clear Thermometers policy would be cleaned a each use. 483.60(c) DRUG R IRREGULAR, ACT  The drug regimen of reviewed at least of pharmacist.  The pharmacist muthe attending physic	cy indicated thermometers nd sanitized before and after EGIMEN REVIEW, REPORT	F 428			12/15/15
	This REQUIREMENT by: Based on interview facility consultant pl	NT is not met as evidenced and document review, the narmacist failed to ensure elidentified and monitored in		Corrective Action- R 203 has been assessed and indications for use or Trazadone have been established.	f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11/0	06/2015
GRAND	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 428	order to determine effectiveness and fa pharmacological int	sleep medication ailed to ensure non terventions had been identified	F 428	pharmacist has reviewed the med The care plan has been updated t the indication for use.	o reflect	
	sleep) medication f received daily medi	rior to the use of hypnotic (for or 1 of 1 resident (R203) who cation for sleep.		Non-pharmacological interventions been added to the care plan and N Corrective Action as it applies to o residents- all residents receiving psychotropic medications have the patential to be effected by this dof	MAR. ther	
	9/4/15, indicated R2 cognitive impairmed assist for mobility, c D0200 of the MDS	Minimum Data Set MDS dated 203 had dementia with severe nt and required extensive staff dressing and toileting. Section did not indicate R203 had any aying asleep or sleeping too		potential to be effected by this def practice. The resident s medicat have been reviewed and indication use are in place. The care plans or residents have been updated to retheir needs. Non-pharmacological interventions have been added to MAR and Care Plans as appropriate of Completion: December 18 Recurrence will be prevented by members have been educated on psychotropic medication indication.	ions ns for of these iflect I the ate. 5, 2015 Staff	
	identification of insolindividualized insolindividualized insolinding the care plan lacked non-pharmacologic before the administ R203's Nursing Ass	ated 9/17/15, lacked omnia or monitoring of onnia symptoms. In addition, devidence that al approaches were tried ration of the medication. Sistant (NA) care plan did not armacological interventions to		use. The use of non-pharmacologinterventions was addressed at the staff educational meetings which wheld on November 30, 2015. Raman MAR audits related to psychotropi medications use and non-pharmacinterventions will be completed daweeks and then weekly for one methen monthly. The Nurse Managand/or DON will be responsible.	gical e all were ndom c cological ily for 2 onth and ers The	
	directed staff to adr	sician's orders dated 10/12/15, minister Trazodone HCL tablet bed time for insomnia.		QAPI committee will determine whaudits may be discontinued. Corrective Action will be monitored DON or Designee		
		rmacist November 2015, ess R203's usage of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  DING		(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11/	06/2015	
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	=		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 428	Continued From pa	ge 78	F 4	428			
	verified R203 received sleeping. RN-A state sleep study assess after the medication stated there was not note related to the ereactions from the record. In addition, plan lacked any independent of the received medication pharmalogical intersigns / symptoms of for. RN-A confirmed	3 a.m. registered nurse (RN) ved Trazadone due to not ed she did not complete a ment prior the initiation of or a was administered. RN-A also documentation or summary effectiveness or adverse medication in R203's medical RN-A verified R203's care ication R203 had insomnia, a to induce sleep, non ventions to be attempted or adverse reactions to monitor dithe consulting pharmacist raddressed R203's sleep.					
F 431 SS=D	undated, indicated reviewed the medic monthly. The consuincluded evaluating medication, what m completed for the mappropriateness of 483.60(b), (d), (e) ELABEL/STORE DR  The facility must enalicensed pharmacof records of receip controlled drugs in accurate reconciliate	Review (Monthly Report), the consultant pharmacist ration regimen of each resident ultant pharmacist's evaluation indications for use of a conitoring was being nedication and the medication.	F4	431		12/15/15	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3) DATE S COMPLI	
		245368	B. WING _		11/06	/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	reconciled.  Drugs and biological labeled in accordary professional principal appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartment controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districts.	maintained and periodically  als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when  State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to keys.  ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can	F 43			
	by: Based on observareview, the facility f were labeled and dresidents (R122) wobserved for medic facility failed to ensign (serum protein derituberculosis infections)	NT is not met as evidenced tion, interview and document ailed to ensure medications ated when opened for 1 of 6 hose medications were eation storage. In addition, the ure expired stock Aplisol vative used to test for on) was discarded after being in 30 days. This had the		Corrective Action- The medication now dated and labeled appropriate Corrective Action as it applies to residents- all residents receiving medications have the potential to effected by this deficient practice, medications of all residents have audited to assure date and label a correct. The nursing staff members	tely.  other  be The been are	

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY IPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE   923 HALE LAKE POINTE   GRAND RAPIDS, MN 55744			245368	B. WING _	·····	11/	06/2015
F 431  Continued From page 80 potential to affect all new admission on 1 of 4 units (Cedar) and newly hired staff.  Findings include:  DoN is overseeing the audits. The medication storage and administration policies have been reviewed and revised as appropriate.  Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to appropriately date and label medications for all residents. All staff educational meeting held on November 30, 2015. Random medication pass and review of medication label audits will be completed daily for 2 weeks and then weekly for one month and then monthly.  The Nurse Managers and/or DON will be					923 HALE LAKE POINTE		
potential to affect all new admission on 1 of 4 units (Cedar) and newly hired staff.  been responsible for the audit and the DON is overseeing the audits. The medication storage and administration policies have been reviewed and revised as appropriate.  Date of Completion: December 15, 2015 Recurrence will be prevented by: Staff members have been educated on the need to appropriately date and label medications for all residents. All staff educational meeting held on November 30, 2015. Random medication pass and review of medication label audits will be completed daily for 2 weeks and then weekly for one month and then monthly. The Nurse Managers and/or DON will be	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
present during the observation and confirmed the Aplisol serum had been open greater than 30 days and should have been discarded to ensure it was not used.  -At 9:04 a.m. R122's Alphagan eye drops were stored in the medication cart was observed opened, used and undated. An unlabeled bottle of lumigan eyedrops was also observed. LPN-E stated the medication belonged to R122, and confirmed the bottle lacked a pharmacy label. LPN-E reported the medication came from the eye doctor, therefore, did not have a label indicating who the medication belonged to or directions for administration. LPN-E confirmed all eyedrop medications should be dated when opened and all medications should have a pharmacy label attached.  On 11/5/15, at 6:36 a.m. the same expired Aplisol vial remained in the Cedar wing medication refrigerator. Licensed Practical Nurse	F 431	potential to affect a units (Cedar) and reserved in the medication storage potency." Licensed present during the Aplisol serum had days and should have anot used.  At 9:04 a.m. R122 stored in the medication opened, used and lumigan eyedrops stated the medicatic confirmed the bottle LPN-E reported the eye doctor, therefore indicating who the directions for admire eyedrop medication opened and all medications of the state of the sta	a.m. an opened multi-dose observed in the Cedar wing room refrigerator with and /15, handwritten on the label. Pharmaceuticals, LLC plisol) included the following age: "Vials in use more than 30 carded due to possible adation which may affect practical nurse (LPN)-E was observation and confirmed the been open greater than 30 ave been discarded to ensure it as Alphagan eye drops were cation cart was observed undated. An unlabeled bottle of was also observed. LPN-E ion belonged to R122, and the lacked a pharmacy label. It medication came from the re, did not have a label medication belonged to or instration. LPN-E confirmed all the should be dated when dications should have a lacked.  6 a.m. the same expired and in the Cedar wing		been responsible for the audit ar DON is overseeing the audits. The medication storage and administration policies have been reviewed and as appropriate.  Date of Completion: December Recurrence will be prevented by members have been educated oneed to appropriately date and lamedications for all residents. All educational meeting held on Nov 30, 2015. Random medication preview of medication label audits completed daily for 2 weeks and weekly for one month and then the Nurse Managers and/or DO responsible. The QAPI committed determine when the audits may discontinued.  Corrective Action will be monitor	the cration of revised of the cration of the cration of the cratic of th	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE APPROPRIED CORRECTION OF THE APPROPRIED CORRECTION OF THE APPROPRIED CORRECTION OF T	D BE	(X5) COMPLETION DATE
F 431		nould have been destroyed and blisol to Registered Nurse	F 4	31		
	medications should and stated the facili order and obtained lumigan eye drops. medication should I the Aplisol should h	a.m. RN-B confirmed all include a pharmacy label, ity should have verified the a pharmacy label for the RN-B stated all eyedropoe dated when opened, and ave been disposed of when it ter opening the vial.				
	(DON) indicated sta medication bottles v drops. The DON si have a pharmacy la	p.m. the director of nursing aff were supposed to date when opened, including eye tated all medications should abel attached unless it was not confirmed the Aplisol disposed of.				
F 441 SS=E	requested but not p	medication storage was provided. I CONTROL, PREVENT	F 4	41		12/15/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	(a) Infection Contro The facility must es Program under whi	tablish an Infection Control				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING		11/	06/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SHOOLD TO THE APPENDED TO TH	OULD BE	(X5) COMPLETION DATE	
F 441	in the facility; (2) Decides what p should be applied t (3) Maintains a reconcions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each direct was hands after each direct contact will tr (3) The facility mus hands after each direct contact will tr (4) The facility mus hands after each direct contact will tr (4) The facility mus hands afte	ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections.  Pad of Infection tion Control Program esident needs isolation to of infection, the facility must in the prohibit employees with a passe or infected skin lesions with residents or their food, if the ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 4	41			
	by: Based on observareview the facility facontrol standards reprotective gloves a community use gluneighborhoods who glucometers. In adeensure proper hand	NT is not met as evidenced tion, interview and document ailed to maintain infection elated to the use of personal appropriate disinfecting of cometers in 8 of 8 outilized community dition, the facility failed to d hygiene and glove use during of eye medication during 1 of 3		Corrective Action- All residents individual blood glucose monitor members have been educated need to wear gloves and proper their hands when administering to resident 122.  Corrective Action as it applies to residents- All residents on bloom monitoring have the potential to	ors. Staff on the rly wash g eye drops o other d glucose		

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY PLETED
		245368	B. WING _		11/(	06/2015
	PROVIDER OR SUPPLIER VILLAGE			STREET ADDRESS, CITY, STATE, ZIP 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	Findings include:  Glucometer:  Norway neighborho  On 11/2/15, at 4:45 (LPN)-G was obse caring a glucomete the Norway dining gloves as she procesugar. Following the placed the glucomedication cart. Land answered a cano time was LPN-C while completing the glucometer or completing the processided on the Norbe cleaned at the eshe did not wear g blood sugar as R6 cares were provide	ministration observations  ood:  5 p.m. licensed practical nurse rved to approach R65 while er (blood glucose machine) in room. LPN-G did not apply seeded to check R65's blood he blood sugar check, LPN-G eter into a caring basket and meter to the top of the PN-G left the medication cart all light on the nursing unit. At G observed to apply gloves he glucose monitoring, sanitize wash her hands after cedure.  I p.m. LPN-G stated the elized for three residents who way neighborhood and was to end of each shift. She verified loves while checking R65's 5 did not like gloves when ed. She verified she did not and did not wash her hands	F 44	effected by this deficient present individual blood glucose mediated for all resider require monitoring. The perfect glucose monitoring was revised as appropriate. So have been educated on the method of hand washing a related to eye drop administ Date of Completion: Dece Recurrence will be prevent members have been educated to appropriately clear glucose monitors and to use wash their hands appropriated administering eye drops. And the seducational meetings were November 30, 2015. Rand glucose monitoring audits administration audits will be daily for 2 weeks and then month and then monthly. Managers and the DON are for these audits. The QAP determine when the audits discontinued. Corrective Action will be mediated to the seducation of the seducation will be mediated.	conitors have ents who colicy on blood viewed and taff members e proper and glove use stration. The most of the completed on the completed weekly for one the name of the name of the completed weekly for one the name of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 441	glucometers were t germicidal "Sani" w On 11/3/15, at 9:44 glucometer on the I R65, R13 and R189 glucometer was to addition, LPN-H sta gloves while comple R65. She stated at of issues with the s procedures.	p.m. LPN-M stated the o be cleansed with a	F	141			
	stated the staff wer the glucometers aft Moose / Wolf Lodge						
	complete R41's blo not apply gloves as R41's blood sugar. glucometer with an glucometer into a c	p.m. LPN-L was observed to od glucose test. LPN-L did she proceeded to check LPN-L then wiped the alcohol wipe, placed the aring basket and returned the op of the medication cart.					
	check on R218. LF she proceeded to c LPN-L then wiped t an alcohol wipe, pla	completed a blood sugar PN-L did not apply gloves as heck R218's blood sugar. he glucometer machine with aced the glucometer into a blaced it on top of the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245368	B. WING _		11.	/06/2015
	PROVIDER OR SUPPLIER  VILLAGE			STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441	glucometer machin residents on the Mo	age 85 that time LPN-L stated the e was used for all the bose/Wolf Lodge and was to n residents with an alcohol	F 44	1		
	should be utilizing glucometers and the	a.m. RN-B stated the staff gloves while completing e machines were to be use according to the facility				
	surveyor a paper the Immediately" each own glucometer. The labeled bag for each calibrated prior to use who had not yet be staff would need to	0 a.m. the DON gave the last stated, "Effective resident would be given their ne meter was to stay in a th resident, all meters would be see and nightly. For residents en supplied a personal meter, disinfect the community meter its with a sani-wipe.				
	Aspen and Birch ne	eighborhood:				
	remove a TrueTRA medication cart. LF test strip, inserted i R38 blood sugar ar of the medication c to clean the glucom At 9:13 a.m. R61 st cart and requested	a.m. LPN-D was observed to CK glucometer from the N-D obtained a glucometer in the glucometer and obtained individual place the glucometer on top art. LPN-D was not observed neter before or after use.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	into the glucometer glucose and returned the medication cart clean the glucometer. At 9:20 a.m. LPN-D to be cleaned with a stated she had not she should have.  On 11/5/15, at 11:20 glucometer utilized monitoring on the Acommunity glucometer utilized monitoring on the Acommunity glucometer the machine stated it was here efollowing our facility. On 11/6/15, at 8:17 neighborhood utilized TRUEtrack glucometer that it is a stated it was here efollowing our facility. At 9:16 a.m. LPN-K had just one commused for checking runit.  At 10:15 a.m. LPN-neighborhood had jTRUEtrack glucometer that is a small properties of the properties of the state of the properties of the properties of the medical properties of the pr	on cart and inserted a test strip, obtained R61's blood ed the glucometer to the top of LPN-D was not observed to er prior to use or following use.  O verified the glucometers were a Sani wipe after each use and cleaned the glucometer as  4 a.m. RN-B verified the by staff to obtain glucose spen and Birch units was a eter and it was facility policy to after each resident use. RN-B expectation for staff to be policy.  a.m. RN-E stated the Spruce ed just one community eter for checking blood sugars  5 stated the Wolf neighborhood unity TRUEtrack glucometer esident blood sugars on this  G stated Norway ust one community eter to used on the unit.  A stated the Rivers	F 4	.41			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245368	B. WING _		11	/06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	completed the block verified the Waters community TRUEt The TRUEtrack gluowner's booklet, daimportant health as WARNING! The True Monitoring System DO NOT share you Device with anyone ALL parts of your E System could carry use, even after cle  The Blood Sampling policy dated 2014, the blood glucose reuse were cleane resident uses. Sing	aters unit stated her supervisor od sugar checks, however neighborhood had just one	F 44	11		
	TRUEtrack manufastated "I had no ide used for one perso that last week, and individual lancet personal thought to look at the glucometers we are verified the TRUEt single use was being on the different unit they were cleaned concern for the tradiseases. The DOI	acturers owner's booklet and ea the glucometers were to be on only. We had talked about I we were planning on going to ens for the residents. I never he owner's booklet for the e currently using." The DON rack glucometers intended for nng used for multiple residents ts in the facility and even if between use, they could be a nsmission of blood-borne N further stated she would get in use right away. The DON				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245368	B. WING _	·····	11/	06/2015
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa verified staff had no glucometers.	age 88 ot followed policy for using	F 44	1		
	Eye drops:					
	stop R122 from ent removed R122's gla eye drops in both e	p.m. LPN-G was observed to tering the dining room. LPN-G asses and proceeded to place yes. At no time was LPN-G oves or wash her hands after rops.				
	administered artific she should have we eye drop medicatio	p.m. LPN-G stated she had ial tears to R122. She verified orn gloves while administering ns and should have washed ministering the medication.				
		eye Drops policy dated 1/2014, outilize gloves while medication.				
	to utilize gloves and medication adminis 483.70(h)	a.m. RN-B stated staff were d wash their hands after eye stration. AL/SANITARY/COMFORTABL	F 46	5		12/15/15
		ovide a safe, functional, ortable environment for the public.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245368	B. WING			11/(	06/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CDAND	VILLAGE			92	3 HALE LAKE POINTE		
GRAND	VILLAGE			G	RAND RAPIDS, MN 55744		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Continued From pa	age 89	F 4	65			
	by: Based on observatoreview, the facility farmrests, resident were maintained in for 1 of 2 residents uncleanable arm refered facility failed to prove of a mechanical (R25) who utilized a facility failed to proven vironment in restrooms (213, 215, 3) were observed to hattached to equipm Lastly, the facility failed to equipm Lastly, the facility failed to equipm Lastly, the facility failed in the food storage clean and sanitary.  Findings include:  R23's wheelchair a uncleanable and the cleanable foam pace of the food storage of the food st	rmrests were torn and e mechanical lift had non dding attached to it. nimum Data Set (MDS) dated R23 had cognitive impairment, ulate and utilized a wheelchair			Corrective Action- The arms rests have been removed and replaced. mechanical lifts of R 23 and 55 have cleaned and repaired as appropriated lap tray of R 25 has been cleaned/replaced as appropriate. It has been removed from all resident equipment. The resident rooms 2 215, 310, 413, 418, 423 and 426 has been cleaned amd equipment and furnishings has been removed/replas appropriate. The kitchen and kit storage areas have been cleaned. Corrective Action as it applies to ot residents: All residents have the plate to be effected by this deficient prace. Resident rooms and the kitchen are have been audited and cleaned as appropriate. The Nurse Managers DON are responsible for the audits cleaning schedule policy has been reviewed and revised as appropriate. Date of Completion: December 15 Recurrence will be prevented by: Recurrence will be prevented by: Recurrence will be prevented by: Recurrence will be prevented on the need to maintain/clean resident room and resident equipment. All staff educational meetings were held on November 30, 2015. The staff methave also been educated on the nemaintain clean kitchens and kitchens to rage areas. Random cleaning will be completed daily for 2 weeks	The ve been te. The Foam te. That te. The room aced tchen tice. The te. The te	
		a.m. R23's wheelchair arm			then weekly for one month and the monthly. The Nurse Managers an	m	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
		245368	B. WING		11/	06/2015
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP COE 223 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 465	On 11/4/15, at 7:10 and NA-H were obswheelchair via a ful hydraulic portion of lift which held the stransfer. The lower had a porous black and secured with bwas peeling away foam padding adde hitting their head on was utilized for R23 armrests were obscinches on both side foam padding expomechanical lift were On 11/5/15, at 6:30 rests had been torr R23's family had apto make them smooremoved.	a.m. nursing assistant (NA)-F served to transfer R23 into the I body EZ mechanical lift. The the lift moved the arm of the ling / resident during the portion of the hydraulic bar foam piece wrapped around it lack adhesive tape. The tape rom the foam. The center of was also observed to have to to prevent the resident from a the bar. NA-H stated the lift an R55. R23's wheelchair erved torn approximately 4-6 as of the arm rest with the sed. The arm rests and the	F 465	DON are responsible for these The QAPI committee will dete the audits may be discontinue Corrective Action will be monit DON or Designee	ermine when ed.	
	(MS)-A stated he d	5 a.m. maintenance staff id not know when the foam It to the mechanical lift. He				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/(	06/2015
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 223 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 465	not create a cleanarecommended intermanufacturer. MS-padding. In addition rests were in need replaced. He state sent a work reques so the repair could stated he would replaced he would replaced. He state sent a work reques so the repair could stated he would replaced. R25's wheelchair lactean and sanitary R25's quarterly MD R25 was cognitively assist with position restraint to prevent was in place.  R25's care plan dat was to have wheeld in wheelchair and shis needs.  On 11/4/15, at 7:52 seated in the wheel with NA-K assisting The lap tray is observed to have a piece taped on with 20 inch edge of the -At 8:54 a.m. NA-K NA-K verified food also on the black for the recommendation of the state of the lapton on the black for the recommendation of the lapton on the black for the recommendation of the lapton on the black for the recommendation of the lapton on the black for the recommendation of the lapton on the black for the recommendation of the lapton on the black for the recommendation of the lapton of the lapton on the black for the recommendation of the lapton of	adding and adhesive tape did ble surface and was not a rventions from the A stated he would remove the n, MS-A verified R23's arm of repair and could easily be d nursing staff should have t to the maintenance director have been completed. MS-A place the arm rests.	F	465			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245368	B. WING			11/0	06/2015	
GRAND	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 465	leaned forward the against his stomach now how often the following character and stated she did on and she just wip.  On 11/06/2015, at this wheelchair, askedebris on the tray a adhesive tape. At the was dirty and the following character and staff were come the tray out and repand cleanable.  On 11/6/15, at 2:10 (DON) verified R25 the tray with the blan of a cleanable and stated staff were we foam that was attacted staff were we foam that was attacted the facility did the use of the foam ENVIRONMENT:  On 11/6/15, from 10 of the facility was comaintenance (DOM following concerns:  -Room 426's upper	ed for cushion so when R25 edge of the tray did press of the NA-K also stated she did not foam was changed or if it was way than wiping it off. NA-K not know how long it had been ed it off when it was dirty.  I:53 p.m. R25 was observed in eep. R25's lap tray has food and on the black foam and his time, RN-B verified tray foam was an uncleanable ed R25 needed the lap tray ing up with a plan to change place it with one that was safe of the porous foam adhered was an increase of sanitary surface. The DON orking towards removing the ched to the equipment and deceptable option. The DON do not have a policy related to a padding or for cleaning it.	F 4	.65				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245368	B. WING _		11	/06/2015	
	PROVIDER OR SUPPLIER  VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COI 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 465	taped on with two in raveling and had do was observed to haby 10 inch wide bla taped to the pipe of the toilet seat.  Room 423's upper inch black porous foom toilet was 14 inch long by 10 porous foam taped toilet, behind the to  Room 213's upper inch black porous f with two inch black had dried debris or with two inch black had dried debris or with two inch black porous f with two inch black porous f with two inch black porous f with two inch black hanging down. The  Room 310's bathroblack tape and two inch section over the The grab bar attached and secur was raveling and he The DOM verified to the proper inch black tape and two inch section over the grab bar attached and secur was raveling and he The DOM verified to the proper inch black tape and two inch section over the grab bar attached and secur was raveling and he The DOM verified to the proper inch black tape and two inch section over the grab bar attached and secur was raveling and he to the proper inch black tape and two inch section over the grab bar attached and secur was raveling and he to the proper inch black tape and two inch section over the grab bar attached and secur was raveling and he to the proper inch black tape and two inch section over the grab bar attached and secure was raveling and he to the proper inch black tape and two inch section over the grab bar attached and secure was raveling and he to the proper inch by the grab bar attached and secure was raveling and he to the proper inch by the proper inch black tape and two inch by the proper inch by the proper inch by the proper inch by the proper inch black tape and two inch by the proper inch by the proper inch by the proper inch black tape and two inch by the proper inch by the proper inch black tape and the	nch black tape which was ried debris on it. The bathroom ave a half inch by 14 inch long ck porous foam tape was in the back of the toilet, behind be black of the toilet, behind be black of the toilet, behind be black of the toilet which was raveling. The sobserved to have half inch by inch wide sheet of black to the pipe on the back of the ilet seat.  To bilateral side rails had three oam attached and secured tape which was raveling and it.  To bilateral side rails had three oam attached and secured tape.  To bilateral side rails had three oam attached and secured tape.  To bilateral side rails had three oam attached and secured tape which was raveling and a tape has dried debris on it.  Toom door frame had two inch inch duct tape covering an 18 ne door latch, frame section. The door latch black porous foam red with black tape. The tape	F 4	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/(	06/2015
GRAND	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 223 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	The DOM stated heremoved and clean foam. The DOM stated heremoved and clean foam. The DOM stated heremoved and clean foam. The DOM stated heremoved infection risks or the verified the foam wastaff had already staff had already with and the following was observed with and alongside and machine. In addition was observed to had gray debris build upperimeter of the floo observed under the The DM verified the sanitary and stated and deep cleaning floors were not clear the entire flooring and the staff had all the sanitary and stated and deep cleaning floors were not clear the entire flooring and the sanitary and stated and deep cleaning floors were not clear the entire flooring and the sanitary and stated and deep cleaning floors were not clear the entire flooring and the sanitary and stated and deep cleaning floors were not clear the entire flooring and the sanitary and stated and deep cleaning floors were not clear the entire flooring and the sanitary and stated and deep cleaning floors were not clear the entire flooring and the sanitary and stated and the sanitary and stated and the entire flooring and the sanitary and stated and the sanitary and sta	a cleaning policy for the foam. It did not think anyone It did not think anyone It did not think anyone It did not the backsides or under the It did not have a It did not hav	F 4	165			
		gular cleaning was scheduled					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245368	B. WING		11/	06/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 465	daily, weekly and m food service area w policy indicated dail floors, sweep and n	ge 95 onthly to ensure that all of the ras washed and sanitized. The y tasks included cleaning the nop including the dry storage counters, fridges, cabinets and	F4	65		

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245368 **B WING** 11/04/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 923 HALE LAKE POINTE **GRAND VILLAGE GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 01 Main Building (1900, 1972, 1992 and 2000 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Grand Village 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483,70(a), Life Safety from Fire, and the

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145



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

TITLE

(X6) DATE

Electronically Signed

11/25/2015

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.

PRINTED: 11/30/2015 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245368 B. WING 11/04/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 923 HALE LAKE POINTE **GRAND VILLAGE GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in

Facility ID: 00298

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
			245368	B. WING	_		11/0	4/2015
	NAME OF F	PROVIDER OR SUPPLIER			9			
	(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 000	between the original addition. It is 1-stor Type II (111) construction and is building was construction and is barriers. In 2011 a 1992 additions was divided into 12 smohour fire rated barr.  The entire building fire sprinkler system 13 Standard for the Systems (1999 edifire alarm system of the corridor in an National Fire Alarm Hazardous areas he that are on the fire rooms have single alarm outside their station that serves the Minnesota State Because the origin conforming structure and the 2004 Sublink was constructed this facility was sur.  The facility has a consult of the conforming structure and the 2004 Sublink was constructed this facility has a consult of the cons	al building and the 1992 west by, without a basement and is ruction. In 2004 the Sub-acute ructed to the north of the the majority of the 1900's sed. It is 1-story, without a termined to be Type V (111) separated by 2-hour fire rated connecting link between the screated. The building is oke zones with 1/2 hour and 1	K	0000			
F		The requirement a	1.72 Of 11, Gubpart 400.70(a) 15					

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

	CENTER	(S FOR MEDICARE	& MEDICAID SERVICES				VID IVO.	0930-0391	
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
١			245368	B. WING			11/0	14/2015	
İ	NAME OF F	PROVIDER OR SUPPLIER	-			REET ADDRESS, CITY, STATE, ZIP CODE  3 HALE LAKE POINTE			
	GRAND V	/ILLAGE	*		92 G				
	(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	K 000	Continued From pa		K	000				
	K 022		FETY CODE STANDARD	K	)22			12/16/15	
	SS=D	visible signs in all o	narked by approved, readily cases where the exit or way to adily apparent to the 1.4						
				51					
		Based on observa facility has failed to required exit doors lead to the public w 101 (00) sections 7 deficient practices residents, staff and	is not met as evidenced by: tion and staff interview, the properly identify several leading to the exterior that vay in accordance with NFPA 7.10.1.7 and 7.10.7.2. These could negatively affect I visitors, by causing confusion from the building to the public i an emergency.			All exit signs will be replaced to m requirements Completion date: 12/16/15 Responsible person: EVS Director		4	
		Findings include:							
		11/04/2015, observing signs that are local are not internally little photoluminescences signs were not visit	e lettering. These same exit ble in low lighting or dark her exit signs located within the						

Facility ID: 00298

	: & MEDICAID SERVICES					
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,				SURVEY PLETED
	245368	B. WING			11/0	4/2015
			92	3 HALE LAKE POINTE		
X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	age 4	K	022			
Maintenance Super NFPA 101 LIFE SA Fire drills are held varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to conqualified to exercise conducted between announcement ma	rvisor. AFETY CODE STANDARD  at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. clanning and conducting drills is competent persons who are e leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible	K	050			12/16/15
Based on review of interview, it was do to conduct fire drill. Safety Code 101(0) 12-month period. Taffect how staff rea	of reports, records and staff etermined that the facility failed in accordance with NFPA Life (0), 19.7.1.2, during the last This deficient practice could fact in the event of a fire.			order to meet requirements. Completion date 12/16/2015		
On facility tour bet 11/04/2015, during maintenance docu the Maintenance S the facility deficien	the review of all available mentation and interview with supervisor it was revealed that t conditions:	t				
	SUMMARY STA (EACH DEFICIENCE REGULATORY OR LE  This deficient pract Maintenance Supe NFPA 101 LIFE SA Fire drills are held varying conditions, The staff is familian that drills are part of Responsibility for passigned only to co qualified to exercis conducted between announcement ma alarms. 19.7.1.2  This STANDARD Based on review of interview, it was de to conduct fire drills Safety Code 101(0 12-month period. The staff is an illian and the staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. The staff real interview it was de to conduct fire drills Safety Code 101(0 12-month period. 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NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents.  Findings include:  On facility tour between 3:00 PM to 6:00 PM on 11/04/2015, during the review of all available maintenance documentation and interview with the Maintenance Supervisor it was revealed that the facility deficient conditions:	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245368  B. WING  PROVIDER OR SUPPLIER  OVILLAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  This deficient practice was verified by the Maintenance Supervisor.  NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. 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WING  PROVIDER OR SUPPLIER  245368  PROVIDER OR SUPPLIER  VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAGE  COntinued From page 4  This deficient practice was verified by the Maintenance Supervisor.  NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by. 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WING  STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744  SUMMARY STATEMENT OF DEPICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DATE OF PROPRIED CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DATE OF THE PROPRIED CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DATE OF CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DATE OF CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DATE OF CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION)  CONTINUE FOR DATE OF CORRECTION REGULATORY OR ISC IDENTIFYING INFORMATION)  K 022  This deficient practice was verified by the Maintenance Supervisor.  NFPA 101 LIFE CONSTRUCTION REGULATORY MUST BE PRECUEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  K 022  This deficient practice was verified by the Maintenance Supervisor.  NFPA 101 LIFE CONSTRUCTION REGULATORY MUST BE PRECUED TO CREATE OR PREPROPERIATE  K 022  This deficient practice was verified by the Maintenance Supervisor.  NFPA 101 LIFE CONSTRUCTION REGULATORY MUST BE PRECUED TO CREATE OR PREPROPERIATE  K 022  This deficient practice was verified by the Maintenance Supervisor.  K 050  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.  Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms.  19.7.1.2  This STANDARD is not met as evidenced by:  Based on review of repor

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 11/04/2015 245368 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 923 HALE LAKE POINTE **GRAND VILLAGE GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 050 K 050 Continued From page 5 quarter, and 2. there were 3 fire drills held in the 10 AM hour and 4 in the 10 PM hour. This deficient practice was verified by the Maintenance Supervisor. 12/16/15 NFPA 101 LIFE SAFETY CODE STANDARD K 056 K 056 SS=D If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. This STANDARD is not met as evidenced by: Sprinkler heads will be replaced by Based on observations and staff interview, it was certified contractor. found that the automatic sprinkler system is not Completion date: 12/16/15 installed and maintained in accordance with Responsible person: EVS Director NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG <b>01 - MAIN BUILDING</b> 01	(X3) DA	TE SURVEY MPLETED
		245368	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		/04/2015
GRAND V	PROVIDER OR SUPPLIER			DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		IVE ACTION SHOULD BE ED TO THE APPROPRIATE	
K 056	Continued From page 6 facility.  Findings include:  On facility tour between 3:00 PM to 6:00 PM on 11/04/2015, observations have revealed that the Woods dinning room area was equipped with quick response sprinkler heads and it is open to the corridor that is equipped with standard response sprinkler heads. This situation has combined two different type of sprinkler heads with in the same compartment.  This deficient practice was verified by the Maintenance Supervisor.			56		
	2					

Event ID: 40YO21

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE

(X3) DATE SURVEY COMPLETED

245368

B. WING

11/04/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

923 HALE LAKE POINTE

GRAND'	VILLAGE	GRAND RAPIDS, MN 55744				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	INITIAL COMMENTS	К0	00			
	FIRE SAFETY					
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.					
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.					
	02 Sub-Acute 2004 Building					
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Grand Village 02 Sub-Acute 2004 Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.		EDOC			
	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:		LFUU			
	Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145		=	Ve) DATE		

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

TITLE

(X6) DATE

**Electronically Signed** 

11/25/2015

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.

Facility ID: 00298

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 02 - SUB ACUTE B. WING 11/04/2015 245368 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 923 HALE LAKE POINTE **GRAND VILLAGE GRAND RAPIDS, MN 55744** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PRFFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 1 K 000 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in

Facility ID: 00298

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - SUB ACUTE B. WING: 245368 11/04/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 923 HALE LAKE POINTE **GRAND VILLAGE GRAND RAPIDS, MN 55744** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 2 K 000 between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

(X2) MULTIPLE CONSTRUCTION

Event ID: 40YO21

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

0.	CENTER	S FOR MEDICARE	& MEDICAID SERVICES				IVID IVO.	0000 0001
	STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				E CONSTRUCTION D2 - SUB ACUTE		SURVEY PLETED
			245368	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/0	04/2015
	NAME OF F	PROVIDER OR SUPPLIER						
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	K 050 SS=D	Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to coqualified to exercise conducted between	FETY CODE STANDARD  at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is empetent persons who are e leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible	К	0.050	2		12/16/15
		Based on review of interview, it was de to conduct fire drills Safety Code 101(0 12-month period. Taffect how staff rea	is not met as evidenced by: of reports, records and staff itermined that the facility failed is in accordance with NFPA Life in accordance with NFPA Life in the last in deficient practice could inct in the event of a fire. by staff would affect the safety			Fire drills will be staggered in time order to meet requirements. Completion date: 12/16/2015 Responsible person: EVS Director		
	0	11/04/2015, during maintenance docu	ween 3:00 PM to 6:00 PM on the review of all available mentation and interview with upervisor it was revealed that t conditions:				2	
THE PARTY OF THE P		quarter, and	t is missing a fire drill in the 4th drills held in the 10 AM hour					
	-	and 4 in the 10 PM	i iloui.					

Event ID: 40YO21

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION UB ACUTE	(X3) DATE SURVEY COMPLETED	
		245368	B. WING			11/0	04/2015
	PROVIDER OR SUPPLIER			923 HA	TADDRESS, CITY, STATE, ZIP CODE LE LAKE POINTE D RAPIDS, MN 55744		
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Electronically submitted November 20, 2015

Ms. Susan Johnson, Administrator Grand Village 923 Hale Lake Pointe Grand Rapids, Minnesota 55744

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5368026

Dear Ms. Johnson:

The above facility was surveyed on November 2, 2015 through November 6, 2015 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, Health Regulation 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.

Grand Village November 20, 2015 Page 2

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 Lyla Burkman at (218) 308-2104 ro email: lyla.burkman@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 Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	11/6/15, surveyors of visited the above prolicensing orders we are completed, pleat copy of these order	rs: i, 11/4/15, 11/5/15, and of this Department's staff, rovider and the following re issued. When corrections ase sign and date, make a s and return the original to the nent of Health, Division of				

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

**Electronically Signed** 12/01/15

TITLE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	<b>VILLAGE</b>		LAKE POIN APIDS, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
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	Compliance Monito Certification Progra Bemidji, MN 56601	m; 705 5th St. N.W., Suite A,				
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			11/30/15
	comprehensive plat objectives and time long- and short-term and mental and psy identified in the con assessment. The comust include the increquired by Minnes subdivision 14, para	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	facility failed to deverestorative nursing program for 1 of 1 r ROM and for 1 of 1	and document review, the elop a care plan to include a range of motion (ROM) resident (R72) reviewed for resident (R203) in the sample tance with ambulation,		Corrected		
	Findings include:					
	9/17/15, indicated F dementia, osteoarth impairment. The MI and had limitations extremities.	num Data Set (MDS) dated R72 was diagnosed with nritis and had severe cognitive DS indicated R72 did not walk in ROM to both lower				
	R72's medical reco	rd note dated 9/5/15, by				

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00298 B. WING 1	/06/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GRAND VILLAGE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
registered nurse (RN)-B indicated a new restorative program for the nursing assistants to complete was initiated. The restorative program included passive range of motion six times per week, provide abduction, adduction, flexion and extension to bilateral shoulders, elbows, wrist, fingers, hips, knees, ankle and toes daily.  R72's medical record note dated 9/9/15, by RN-D indicated R72 had ROM limitations to bilateral lower extremities, was wheelchair dependent and required total staff assistance for wheelchair mobility and was at risk for decline in ROM. The note indicated a restorative program would be set up in order to prevent any decline.  R 72's care plan dated 12/19/14, indicated R72 was transferred with two staff and an E-Z lift and utilized a wheelchair for mobility. The care plan failed to include the restorative nursing program.  On 11/6/15, at 1:03 p.m. RN-B confirmed R72's restorative program was not identified on R72's care plan and stated it had just got missed.  R203's admission minimum data set (MDS) dated 9/4/15, identified R203 had a severe cognitive impairment and diagnoses which included non-Alzheimer dementia and hypertension. The MDS indicated R203 required extensive assist from staff for bed mobility, transfers, dressing, tolleting, and ambulation.  R203's physical therapy (PT) discharge note dated 9/11/15, indicated R203 was to walk to meals.	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00298	B. WING	<del></del>	11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 3	2 560			
		to walk to meals and to the with assist of one staff and				
	R203 with a front w one staff. The care	ated 11/4/15, directed staff to heeled walker and assist of plan failed to include the program / the frequency of the				
		p.m. before the dinner meal to be wheeled to the dining				
	assisted R203 with 4 wheeled walker (a move from the bed chair, while NA-A ar	a.m. nursing assistant (NA)-A morning cares. R203 used a an assistive walking device) to and transfer into her wheel nd NA-B used a gait belt to wheeled her to the dining				
	rarely attempted to not go for walks any could walk a couple standing with her wataking several steps recliner. NA-A state and needed to sit do due to being unstea	a.m. NA-A stated R203 very self transfer any more and did ymore. NA-A stated R203 of steps which involved R203 alker placed in front of her and is to the wheelchair or the d R203 really leaned forward own shortly after she stood ady. NA-A stated it had been to R203 had walked to the				
	verified R203's care restorative nursing stated R203 was to recommended by the	5 a.m. RN-A unit manager e plan did not include the plan / walking program. RN-A be on a walking program as ne PT however, the task for nts to complete was never put				

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Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00298	B. WING	<del></del>	11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE	·	LAKE POIN APIDS, MN	<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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 4	2 560			
	into the computer the aware of R203's am	neretofore the NA's were not nbulation program.				
		policy dated 9/2013, directed according to the residents'				
	The administrator of revise policies and development of resthey comply with the	THOD OF CORRECTION: or designee could review and procedures pertaining to the ident care plans to assure the regulations and education monitoring procedure.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			11/30/15
		omprehensive plan of care personnel involved in the .				
	by: Based on observati review, the facility fa directed by the indiv residents (R99, R23 assistance with ora (R23) who required	ent is not met as evidenced on, interview and document ailed to provide services as vidual care plan for 2 of 2 B) in the sample who required I cares, for 1 of 3 residents assistance perineal cares and (R122, R65) who were to		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
	PROVIDER OR SUPPLIER	923 HALE	LAKE POIN			
<u> </u>		GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	receive restorative i	nursing rehabilitation services.				
	Findings include:					
	R99 did not receive care plan.	oral cares as directed by the				
		ed 12/17/14, directed staff to for oral cares twice a daily and .				
	assistant (NA)-G wa morning cares. At r oral cares. -At 7:26 a.m. R99 w room for breakfast. -At 8:50 a.m. after t from the breakfast t	10 a.m. until 7:26 a.m. nursing as observed to assist R99 with no time did NA-G offer R99 was assisted to the dining the meal, NA-H assisted R99 table into the restroom. At no erved to offer oral cares.				
	were to be complete	a.m. NA-H stated oral cares ed before breakfast. She offered or provided R99 oral l.				
		a.m. NA-G verified she had ded R99 oral cares and should g cares.				
		a.m. registered nurse (RN)-A have completed R99's oral y the care plan.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  CONTROL OF THE PROPERTY OF T	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	R23 did not receive as directed by the c	oral cares or perineal cares are plan.				
	not have teeth and cares twice a day. I staff to provide peri	ed 1/7/15, indicated R23 did directed staff to provide oral The care plan also directed neal cares after each and to utilize protective skin				
	provide R23 with m observed to be total complete the task at communicate.  -At 6:20 a.m. NA-H assisted NA-G with -At 6:30 a.m. R23 with a wheelchair via a fight -At 6:35 a.m. R23 with table.  -At 8:57 a.m. NA-H room to her room. transferred R23 to bight -At 9:00 a.m. NA-H check R23's incontible was observed NAs removed the bight no time were the NAs ocares.  On 11/5/15, at 9:05	vas transferred from the bed to ully body mechanical lift. vas wheeled to the breakfast wheeled R23 from the dining NA-G and NA-I assisted R23				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	perineal cares were incontinent episode provided R23 oral oral directed by the care.  On 11/5/15, at 9:15 not completed oral.  On 11/5/15, at 9:20 and perineal cares directed by the care directed by the care directed by the care set double to left sided he R122's Restorative included the additio splint/brace training	e to be provided after an . NA-H verified she had not eares or perineal cares as e plan.  a.m. NA-G verified she had cares during morning cares.  a.m. RN-A stated oral cares were to be completed as e plan.  e her rehabilitation services directed by her care  ated 11/6/15, directed staff to orative nursing program plan specific needs / services to be estorative program date R122 was to receive active DM) to right upper extremities miplegia and weakness. program dated 5/14/15, n of R122 was to receive to left hand and gentle st. Both programs were to be	2 565	DEFICIENCY)		
	bed. R122 stated si services six days a getting the services Mon-Wed. (11/2/15	a.m. R122 was observed in ne was to receive rehab week and she had not been . R122 stated this week, -11/4/15) she had not received wever. R122 stated vesterday				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF PRO	OVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND VIL	LLAGE		LAKE POIN APIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
sib gda woth bth Civia pwthin Civia dhiddidididi Rai Prepire	reing she had attented rehab services. Repartment was to land that was not have eks, the department was to land that was not have eks, the department was and the ecause the rehab she floor.  On 11/05/15, at 2:15 erified R122 had not sindicated on her work on the floor. Repartment was provided at the properties of the rehab was provided at the properties of the received week as directed at the properties of the properties o	attend a Christian activity and ided the activity, she could not R122 also stated the rehab be open seven days a week appening. R122 stated some ient cut down to being open someday's they just closed was no rehab provided staff were pulled to work on 5 p.m. rehab aid/TMA-A ot been receiving her rehab restorative plan due to being ab department and having to ehab aid/TMA-A stated when rehab doors were closed and ded for any of the residents.  O a.m. RN-B reviewed and a plan and rehab directives as to receive the services six irected. RN-B verified R122 ring rehab services as directed aff being pulled from the rehab rehabilitation services 6 days	2 565			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING	·····	11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	ankle weights-kick a seven day per week restorative dressing active ROM bike 20 repetitions, clothes free weights 30 reprovided six days a On 11/5/15, at 7:35 receiving rehab serbe receiving the serbe receiving the serbe and Sunday (11/1/1 and part of Tuesday)	and march's 30 repetitions  and march's 30 repetitions  The program also included and grooming which included to turns, Red Flex bar 20 pin and cord sort 1 time and etitions which was to be week.  a.m. R65 stated she was not vices. R65 stated she was to vices six days a week and the sed both Saturday (10/31/15) 5) and also Monday (11/2/15) (11/3/15). R65 stated the lled to work the floor so they	2 565			
	days when Rehab v of staff and it was u verified it also happ LPN-F stated R65 v program and she di On 11/5/15, at 2:08 R65's rehab plan di per week but R65 w	p.m. rehab aide/TMA-A stated rected R65 to attend six days rould come seven days a				
	On 11/6/15, at 10:20 a rehab program who day per week. RN-E	ed R65 had not received by the care plan.  D a.m. RN-B verified R65 had nich was to be provided six confirmed R65 had not es as directed by the care				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00298	B. WING		11/0	06/2015
	PROVIDER OR SUPPLIER	923 HALE	DRESS, CITY, S LAKE POIN APIDS, MN			
(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)	D BE	(X5) COMPLETE DATE
2 565	The Care Planning staff to provide care individual care plan  A SUGGESTED MET The director of nurs the policies and procare plans. She or education to all invodevelop a monitoring compliance and rep Assurance Commit	policy dated 9/2013, directed e according to the residents'.  ETHOD FOR CORRECTION: sing could review and revise ocedures related to following designee could provide blved staff. The facility could no system to ensure ongoing port the findings to the Qualify	2 565			
2 570	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required	2 570			11/30/15

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING	<del></del>	11/0	6/2015
	PROVIDER OR SUPPLIER	923 HALE	DRESS, CITY, S LAKE POIN APIDS, MN			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Based on observati review, the facility fa include the current	ge 11 on, interview and document ailed to revise the care plan to passive range of motion or 1 of 5 residents (R23)	2 570	Corrected		
	Findings include:					
	dependent on staff The plan directed s	ed 4/8/15, indicated R23 was for all activities of daily living. taff to perform restorative directed by the nurse				
	program directed accomplete PROM what upper and lower ex. The goal was to enability to sit in her was daughters hand dur	ant Point of Care (POC) ctivity staff members to nich included stretching to the tremities for ten repetitions. sure R23 maintained the rheelchair and hold her ring visits. The documentation aff as to which joints were to				
	provide morning ca to open R23's left h to move the should. The left elbow did n then washed the rig able to open, but th 90 degrees. The le the left shoulder wa order for the staff to	a.m. NA-G was observed to res for R23. NA-G was able and to wash it. She was able er slightly to wash under it. ot extend during cares. NA-G th side. The right hand was e fingers did not extend past ft elbow did not extended and as able to be moved for R23 in wash under the arm. oper extremities were unable.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED	
00298		B. WING		11/06/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO THE OT	THO VIBERT ON COLL FIELD		LAKE POIN			
GRAND	VILLAGE		APIDS, MN			
(V4) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	)NI	(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IGIENGT)		
2 570	Continued From pa	ge 12	2 570			
	-					
	Δt 6:15 a m NΔ-H	entered the room to assist with				
		IA-G completed lower body				
		emained in a pointed position				
		taff assisted with donning				
		were observed to remain				
		y bent at the knees as the NAs				
		cares and donning pants.				
	NA-H stated R23 had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move. NA-H stated R23 had not changed in the past					
	year.	ad not changed in the past				
	your					
	On 11/5/15, at 11:20	6 a.m. R23 was observed to				
		ge of motion from AA-A while				
		chair. AA-A was observed to				
		hands, elbows and shoulders.				
		petitive movements on each				
	joint. She was able to fully extend R23's left					
		w and shoulder did not fully				
	extend. R23's right hand was able to be opened, but the fingers were not observed to be					
		elbow and shoulder were				
		ot observed to be fully				
		a.m. AA-A knelt on the floor				
		g exercises for R23. AA-A				
		nd knees while she was				
		At no time did AA-A observed				
	to attempt to do pas	ssive ROM to R23's feet.				
	On 11/0/15 -+ 0:00	om DN Charified the series				
		a.m. RN-C verified the care				
	to complete passive	evised to direct the staff how				
	to complete passive	FILOWI IOI 1123.				
	The Care Planning	policy dated 9/2013, directed				
		ne care plans according to				
	resident need.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '66			ATE SURVEY OMPLETED	
	A. BUILDING:						
		00298	B. WING		11/06/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GRAND '	VILLAGE		LAKE POIN APIDS, MN				
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 13	2 570				
2 920	The director of nurse the policies and proof care plans. She education to all invodevelop a monitoring compliance and repart Assurance Commit TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one	2 830			11/20/15	
2 630	Subpart 1. Care in receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must 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 ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	2 830			11/30/15	
	Based on observati review, the facility fa	on, interview and document ailed to to ensure there was e for 1 of 1 (R117) resident		Corrected			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
GRAND VILLAGE 923 HALE			LAKE POIN			
		GRAND F	RAPIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	facility failed to prov	e services and in addition the ride proper wheelchair 1 resident (R72) reviewed for ing.				
	Findings include:					
	Hospice					
	facility and hospice	hospice services and the agency had not coordinated es R117 was to receive.				
	6/10/15, indicated in Hospice. The reconsinterventions described home health aide (Fig. 1)	ord progress noted dated ndicated R117 was admitted to d lacked individualized bing how often the hospice HHA) would visit, what day the what services the HHA would				
	9/16/15, indicated F cancer, anemia, ma	nimum Data Set (MDS) dated, R117 diagnoses included alnutrition and was terminal. R117 was totally dependent ies of daily living.				
	R117's care plan da would direct care fo	ated 6/22/15, indicated hospice or pain/discomfort.				
	9/8/15, indicated a l times per week to p care, peri-care, dres	e plan for the HHA updated on HHA would visit one to two provide mouth care, fingernail ssing, transferring, bathing as toileting, socialization and				

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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	
		00298	B. WING		11/06/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 15 tidy room. Facility Contact forms included the visit date, what discipline from the hospice agency		2 830			
	visited R117, collab next planned visit.	oration with facility staff and				
		Contact forms from 8/17/15, vealed the hospice HHA had nes as follows:				
	-On 8/26/15, the hospice HHA noted P117 was assisted with lunch. The section for collaboration with facility staff was blank and the section for next planned visit was also blankOn 9/9/15, the HHA noted R117 was assisted with lunch. The section for collaboration with facility staff was blank and the section for next planned visit was also blankOn 10/23/15, the HHA had documented collaboration with facility staff but the section for next planned visit was blankOn 10/30/15, the HHA indicated R117 was sleeping and the facility nurse reported no concerns. The section for collaboration with facility staff was blank and the section for next planned visit was also blank.					
	nurse (RN) -B was of care with hospice R117. RN-B stated and the facility did r	oximately 2:30 p.m. registered questioned about coordination a staff when the agency visited there was no set schedule not know what day, when or ice HHA made visits.				
	seated in a wheelch taking a few bites o	a.m. R117 was observed hair at the dining room table f her breakfast. R117 was ere closed most of the time by very lethargic.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BOILDING.				
		00298	B. WING		11/0	6/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRAND	VILLAGE		ELAKE POIN PAPIDS, MN				
(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)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 16	2 830				
	was questioned about hospice HHA provided facility. NA-E stated when the HHA visited HHA came, sometime extra bath and if the might assist R117 v. On 11/6/15 at 8:40	a.m. RN-B stated the hospice					
	RN came to the face explained R117's castated the HHA did visits because their they came when the facility did not know were coming or what providing. RN-B conservices were not were to the services.	ility last evening, 11/5/15, and are plan. The hospice nurse not have a set schedule for hospice case load varied so ey could. RN-B verified the when the hospice HHA staff at services they would be nfirmed R117's hospice					
	was interviewed on hospice HHA was s Friday but the time HHA's prior visits of The nurse indicated collaborated with th	a.m. R117's hospice nurse the telephone and stated the supposed to visit R117 every varied depending on the f the day and the case load. If the HHA should have e facility staff and their next planned visit would					
	with R117 most day hospice HHAs visite	a.m. NA-E stated she worked as and was not aware the ed R117 on Fridays. NA-E also aware of the hospice and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa facility contact shee dates listed of the n	t which would have had the	2 830			
	stated hospice agei or calendar to indica	O a.m. the director of nursing ncy's used to have a schedule ated when they would be at at is not the process now, then nged.				
	January 2014, indic participated in the h coordinated plan of hospice agency and developed and wou managing pain and symptoms. The car	Program policy revised ated when a resident ospice program, a care between the facility, dresident/family would be ld include directives for other uncomfortable e plan shall be revised and ary to reflect the patient's				
	Wheelchair position	ning:				
		oning assistance and the st and identify the need for a chair.				
	9/7/15, indicated R7 dementia, osteoarth and heart disease. cognitive impairmen required extensive and extensive assis mobility / locomotion	num Data Set (MDS) dated 72 was diagnosed with nritis, chronic kidney disease The MDS indicated R72 had nt, was non ambulatory, assist of two staff for transfers of one staff for wheelchair n on and off the unit. The R72 was non-ambulatory.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00298	B. WING		11/0	6/2015
NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE	923 HALE	DRESS, CITY, S LAKE POIN APIDS, MN			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
had cognitive impair communicating wan to anticipate R72's r was transferred with utilized a wheelchair to use foot pedals or out of the room or or of the room or of the room	ed 12/19/14, indicated R72 ment and difficulty ts / needs and directed staff needs. The plan indicated R72 a E-Z mechanical lift and for mobility and directed staff in the wheelchair if R72 was ff unit.  therapy (OT) care plan dated by OT-A on 8/9/15, indicated therapy due to multiple bluded dementia, abnormal nificant decline in wheelchair in indicated R72 required skill unctional activities of ing. R72's short term goal ated R72 would position feet is in order to maintain proper fort. R72's long term goal ated R72 would maintain if legs on elevating leg rest at maintain proper positioning  15 a.m. R72 was observed air with feet extended past sting on top of the edge of the of resting flat on the pedals. A A who was the director of ified R72's feet were not on the foot pedals. OT-A chair did not fit him and would evaluation for proper	2 830			

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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
		00298	B. WING		11/0	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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	Continued From pa	ge 19	2 830			
	(LPN)-D stated R72 not wheeled his who required the use of	5 a.m. licensed practical nurse 2 had a recent decline and had eelchair anymore therefore the foot pedals. LPN-D stated otal staff assistance for all				
	evaluated for wheel and at that time foo wheelchair. OT-A si followed up on the	2 a.m. OT-A stated R72 was chair positioning on 7/2/15, t rests were added to the tated the facility should have effectives of R72's foot pedals by were initiated, but it had cracks.				
	seated in a wheelch One of R72's feet w pedal and the other	5 a.m. R72 was observed nair in the television room. vas resting on top of the foot foot had slid off the side of was resting on the floor.				
	stated an evaluation was just completed had motion availabl was resistive to ran	0 p.m. the physical therapist of R72's lower extremities and it was determined R72 e in the lower extremities but ge of motion. The PT stated propriately placed on the foot t leave them there.				
	stated R72's knees sure if the arthritis h declining in range o R72's foot pedals w	p.m. registered nurse (RN)-B had gotten stiffer and was not had worsened or if R72 was of motion. RN-B confirmed here not appropriate for him had be evaluated by OT for				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
	also be assessed b	ing. RN-B stated R72 would y nursing to determine if R72's stiffness of the knees needed changed.				
	A policy and proced was requested but	ure for wheelchair positioning was not provided.				
	The director of nurs the policies and pro resident wheelchair of hospice services provide education to could develop a mo	ETHOD FOR CORRECTION: sing could review and revise cedures related to monitoring positioning and coordination. She or designee could all involved staff. The facility initoring system to ensure and report the findings to the committee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 895	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	2 895			11/30/15
	that is directed towa through positioning implemented and m comprehensive res of nursing services development of a n provides that:	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	B. a resident wit	h a limited range of motion				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00000			44/0	0.0045
NAME OF I	PROVIDER OR SUPPLIER	00298 STREET ADI		STATE, ZIP CODE	<u>  11/0</u>	6/2015
	VILLAGE	923 HALE	LAKE POIN	ITE		
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pareceives appropriate increase range of modecrease in range of the decrease in comparison of the decrease in range of the decrease in comparison of the decrease in comparison of the decrease in comparison of the decrease in the decrea	age 21 The treatment and services to notion and to prevent further of motion.  The provided is not met as evidenced and interview and document alled to provide range of order to prevent a decrease or notion (ROM) ability for 3 of 3 2, R122) in the sample who	2 895			
	indicated R23 had I	essment dated 9/28/15, limitations in ROM on one side nity and had no limitations in es.				
	R23's care plan dat	ted 4/8/15, indicated R23 was				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 11/0	0/2010
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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
2 895	living and directed	ge 22 aff for all activities of daily staff to perform restorative ervices as directed by the	2 895			
	program directed the passive ROM exercitor to the upper and low repetitions each. T	stant Point of Care (POC) ne activity staff to provide R23 cises which included stretching wer extremities for ten he goal was to ensure R23 ity to sit in her wheelchair and hand during visits.				
	documentation for the had revived ROM for	orative Passive ROM October 2015, indicated R23 or 20 minutes six days a week. I did not identify which joints or ROM.				
		al record lacked progress 3's progress or regression of gram.				
	and NA-H were obsided into a wheelchalift. R23's hands we (loose) fisted position move her arms or his throughout the obsided rate of the control of the con	a.m. nursing assistant (NA)-F served to transfer R23 from air via a full body mechanical are observed to be in a closed on. R23 was not observed to her legs independently ervation.  was observed to apply tectors to R23's arms. R23 application. NA-H applied a 23's shoulders and elbows to extend to assist with the weater. R23's hands remained				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			71. BOILDING.			
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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
2 895	p a minimum p a	during the application of the	2 895			
	feed R23 the break observed to move he totally dependent upor At 9:15 a.m. NA-G transfer R23 from the mechanical lift. On provided R23 with in were observed slight clamped together at total provided R23 with in the clamped together at total provided R23 with in the clamped together at total provided R23 with in the clamped together at the c	a.m. NA-F was observed to fast meal. R23 was not ner upper extremities and was pon the staff for meal. and NA-F were observed to he chair to bed via the ce in bed, NA-G and NA-F ncontinence cares. R23's legs at bent at the knees and and her feet were observed to roward position (foot drop).				
	stated R23 received week during activiti staff completed arm 20 minutes each da arms and legs had	p.m. activity aide (AA)-A d passive ROM six days a es. AA-A stated the activity n and leg repetitions for about ay. AA-A also stated R23's been "tight" but were much med stronger after receiving ROM.				
	provide morning ca to open R23's left h R23's left shoulder left elbow did not ex also able to open R however, R23's find degrees. R23's right shoulder was able to cleansing. NA-G sta were unable to be f	a.m. NA-G was observed to res for R23. NA-G was able and and wash it and move slightly to wash under it. The xtend during cares. NA-G was 23's right hand to wash, gers did not extend past 90 at elbow did not extend and the to be moved to allow for ated R23's upper extremities ully extended.				

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AND BLAN OF CORRECTION	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00298 B. WING		11/06/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST			
GRAND VILLAGE 923 HALE LAKE POINT GRAND RAPIDS, MN 5			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
with cares. NA-H and NA-G both completed R23's lower body cares. R23's feet remained in a foot drop as staff assisted with donning socks. R23's legs were observed to remain together and slightly bent at the knees as the NAs completed perineal cares and applied R23's pants. NA-H stated R23 had always been "tight" when completing cares. NA-H stated she had worked at the facility for the past two years and R23 had always had limitations in her ability to move. NA-H stated R23 had not changed in the past year.  On 11/5/15, at 9:20 a.m. registered nurse (RN)-D stated she completed the MDS but did not complete bedside ROM assessments on dependent residents'. RN-D stated all MDS coding was transcribed from the Nursing Assessment which was completed by the RN-A -At 9:25 a.m. RN-D was observed to complete ROM for R23 while R23 was in bed. RN-D stated R23 displayed bilateral upper and lower limitations in range of motion in the shoulders, elbows, hands and hips, knees and feetAt 9:40 a.m. RN-D verified the MDS was not coded correctly as it did not identify R23's limitations in ROM in both upper and lower extremities. At the same time, RN-A verified she had completed R23's 9/28/15, Nursing Assessment, and stated at that time, R23 only had limitations on one side of her body. RN-A stated she completed the ROM assessment at the bedside for all dependent residents.  On 11/5/15, at 11:26 a.m. AA-A was observed to perform passive ROM exercises for R23 while R23 was seated in the wheelchair. AA-A was			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	and shoulders. AA-movements on each extend R23's left has shoulder did not full was able to be open observed to be strashoulder were move be fully extendedAt 11:37 a.m. AA-A to do leg exercises hip and knees while At no time was AA-passive ROM to R2-At 11:43 a.m. AA-A On 11/5/15, at 11:45 RN had trained her She stated she had for greater than a yelimitations in ROM a changed in the past did she complete R On 11/5/15, at 11:50 observed AA-A perfinot completed any to AA-A's ROM prog AA-A would report a On 11/5/15, at 2:20 identified concerns abilities were all new RN-C was in charge and any concerns we documentation.	A completed repetitive h joint. She was able to fully and. The left elbow and y extend. R23's right hand ned, but the fingers were not ightened. The elbow and ed, but were not observed to a knelt on the floor and began for R23. AA-A moved R23's e she was seated in the chair. A observed to attempt to do 3's feet. A completed the cares.  5 a.m. AA-A stated a former to complete ROM exercises. been assisting R23 with ROM ear. AA-A verified R23 had ability but they had not a year. She verified at no time	2 895			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015
	PROVIDER OR SUPPLIER	923 HALE	DRESS, CITY, S'ELAKE POINTRAPIDS, MN	ΓE		
(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
2 895	the restorative program attended the restorative program attended the restorative program attended the restorative program attended the restorative programing completed restorative programing completed restorative sidents including for RN-C to locate a related to R23's rescurrent medical recevaluations.  On 11/6/15, at 8:30 completed the MDS onto the nursing unassessments. She the MDS according documentation. RN Assessment complete the assessment equarterly MDS on RN-D would have ounits and personally when needed to change the documentation com RN-D was not experience and restoration to the cordinated R23's past Physical Therapy Eindicated R23's past Physical Therapy Eindicated R23 had a initiated at which times the state of the cordinated R23 had a sinitiated at which times the cordinated R28/14 a initiated at which times the cordinate R28/14 a initiated	ram liaison. She stated staff monthly basis to review the at RN-C stated AA-A had not ative meetings nor provided the residents' receiving ROM ff. RN-C stated any ted to the restorative ted by AA-A would be up to RN-A verified she had not ve reviews on AA-A's R23. The surveyor requested any therapy documentation torative program as the ord did not contain therapy	2 895			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	11/0	<u>5/2013</u>
GRAND '	VILLAGE		LAKE POIN			
040.15	CLIMMA DV CT/		APIDS, MN			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 27	2 895			
		ed 10/16/14, between herself RN-A indicated R23 was no				
	be receiving ROM t further foot drop. -At 8:47 a.m. RN-D several long term s R23's ROM had no - At 9:00 a.m. RN-C program policy dire- monitor the residen	a.m. RN-C stated R23 should to her feet in order to prevent stated she had interviewed taff members who all indicated t changed in the past year. Stated the facility restorative cted the unit mangers to its' ROM program to ensure the necessary services to orther decline.				
		e range of motion services to s in range of motion.				
	was diagnosed with had severe cognitiv	dated 9/17/15, indicated R18 n dementia, osteoarthritis and re impairment, bilateral lowers in ROM and did not walk.				
	utilized a wheelchai staff and an E-Z me	ted 12/19/14, indicated R72 ir and was transferred with two echanical lift. The care plan did ng restorative program.				
	program note dated had late entry next of described R72 as had lower extremities in R72 was able to fleankles, hips and all	ord included a restorative d 9/9/15, written by RN-B and to the date. The note naving limitations to bilateral a both knees. The note indicate ox and extend, invert and avert other joints of the lower the indicated R72 was at risk				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 11/0	0/2013
	VILLAGE		LAKE POIN			
GRAND	VILLAGE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 28	2 895			
	and required staff a destinations. The fu program would be s	was wheelchair dependent assist to propel to all arther indicated a restorative set up in order to prevent any buld be re-evaluated next				
	initiated a new restor NAs to complete. T passive range of m directed staff to pro- flexion and extension	rd indicated on 9/5/15, RN-B brative program for R72 for the he program consisted of otion six times per week and wide abduction, adduction, on to bilateral shoulders, rs, hips, knees, ankles and				
	seated in a wheelch	15 a.m. R72 was observed nair with both legs extended ting on top of the foot pedals, als.				
	(LPN)-D stated R72 R72 no long wheels	5 a.m. licensed practical nurse 2 had a recent decline in which ed own wheelchair, hardly fed d to an required total staff ning needs.				
	indicated PROM was September on 9/6/1	b schedule was reviewed and as only completed two times in 15, and 9/20/15. There was no competed in October or				
		p.m. RN-B stated a task form				

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nursing staff to complete and sign off when

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	completed. RN-B conly signed off as b RN-B verified R72's documentation which provided to R72.  R122 did not receive minimize limitations directed by the care R122's quarterly MIR122 was diagnose on one side of the balso indicated R122 ROM on one side of required extensive daily living.  R122's Activities of 2/23/15, indicated R122 was (PT) and occupation rehabilitation and as steps in physical the R122's care plan, dorefer to nursing resiprogram specifics. dated 3/25/15, indicated R122's care plan, dorefer to nursing resiprogram specifics. dated 3/25/15, indicated R122's care plan, dorefer to nursing resiprogram specifics. dated 3/25/15, indicated R122's care plan, dorefer to nursing resiprogram specifics. dated 3/25/15, indicated R122's care plan, dorefer to nursing resiprogram specifics.	onfirmed R72's PROM was eing completed only twice. It is record had no other the indicated ROM had been are range of motion services to sin range of motion (ROM) as explan.  OS dated 8/20/15, indicated ed with hemiplegia (paralysis body) and anxiety. The MDS explan had intact cognition, limited if the upper / lower body and assistance with all activities of assistance with all activities of the left side. The CAA is receiving physical therapy and therapy (OT) for that time R122 was taking 3 erapy.  ated 11/6/15, directed staff to torative documentation for R122's restorative program cated R122 was to receive to the upper extremities.	2 895	DEFICIENCY		
	R122's restorative prindicated R122 was training to the left h	es to the upper extremities.  brogram dated 5/14/15,  to receive splint / brace  and and gentle stretching of  rams were to be provided six				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
2 895	Continued From pa	ge 30	2 895			
	days per week.					
	bed. R122 stated si services six days a getting the services Mon-Wed. (11/2/15- rehab. However, R1 chosen to attend a she had attended the rehab services. R1 department was to and that was not hat weeks, the department only three days a we closed the doors and	a.m. R122 was observed in the was to receive rehab week and she had not been and R122 stated this week and received l22 stated yesterday she had Christian activity and being the activity, she did not get laso stated the rehab be open seven days a week appening. R122 stated some leent cut down to being open leek and someday's they just and there was no rehab the rehab staff were pulled to				
	medication aide (TM received rehab services restorative plan due rehab department a floor. Rehab aid/TM happened, the rehab was provided On 11/6/15, at 10:20 verified R122's care and stated R122 was days per week as dhad not received re	5 p.m. the rehab/ trained MA)-verified R122 had not vices as directed on here to being pulled from the and having to work on the IA-A stated when that b doors were closed and no I for any of the residents.  O a.m. RN-B reviewed and e plan and rehab directives as to receive the services six irected. RN-B verified R122 hab services as directed due eing pulled from the rehab				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)			K3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GRAND	VILLAGE		E LAKE POIN PAPIDS, MN				
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 895	The undated, Restorthe objective was diresident to achieve level of self-care the motion and ambulation the residents' would admission by PT/O determine goals and upon discharge from the Care Planning staff to provide care individual care plan.  Suggested Method Nursing or designed interdisciplinary teal limitations in range receiving the necess maintain their range could consider having provide oversite for range of motion. The Committee could provide delivery of care are being offered self-care are being offered self-care to achieve the self-care are being offered self-care to achieve the self-care to achieve th	prative Care Policy indicated irected toward assisting each and maintain their highest rough positioning, range of tion. The policy also indicated to be assessed at time of T whereby PT/OT would devel of restorative care in PT/OT therapy services.  policy dated 9/2013, directed exaccording to the residents'.	2 895				
2 915	•	5 Subp. 6 A Rehab - ADLs	2 915			11/30/15	
	comprehensive resindent comprehensive resident comprehensive residen	of daily living. Based on the ident assessment, a nursing that: given the appropriate					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 915	treatments and servabilities in activities deterioration is a not the resident's condipart, activities of daresident's ability to:  (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech functional commun	vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ass, and groom; and ambulate; let; h, language, or other ication systems; and	2 915			
	by: Based on observati review, the facility for consistently implem improve and/or mai abilities for 1 of 1 reviewed for restorations and for 1 of	ent is not met as evidenced ion, interview and document ailed to provide and nent ambulation services to intain residents' ambulation esident (R203) in the sample ative nursing ambulation of 1 resident (R65) in the or rehab nursing services.		Corrected		
	R203's admission Mated 9/4/15, indicadementia, had sever required extensive mobility, transfers, ambulation. R203's Area Assessment of	Minimum Data Set (MDS) ated R203 was diagnosed with ere cognitive impairment and assistance from staff for bed dressing, toileting and Activities of Daily Living Care dated 9/11/15, indicated R203 cal therapy (PT) and				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING	<del></del>	11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 33	2 915			
	occupational therap and independence.	by (OT) to increase strength				
	R203's PT dischargindicated R203 was	ge therapy note dated 9/11/15, to walk to meals.				
	indicated R203 was	ve Care sheet dated 9/16/15, s to walk to meals and to the vith assist of one staff and				
	R203's care plan, dated 11/4/15, indicated R203 was to ambulate with a front wheeled walker and assist of one staff. However, the plan did not address R203's restorative program.					
	On 11/2/15, at 5:00 wheel R203 into the	p.m. staff were observed to e dining room.				
	was observed to as NA-A applied a tran and assisted R203 walker (an assistive self from the bed ar	a.m. nursing assistant (NA)-A sist R203 with morning cares. Isfer belt around R203's waste as she utilized a four wheeled walking device) to transfer and into the wheelchair. NA-A e dining room for breakfast.				
	rarely attempted to longer went for wall walk a couple of ste walker in front of he	a.m. NA-A stated R203 very self transfer any more and no ks. NA-A stated R203 could eps such as standing with her er and transferring taking wheelchair or the recliner.				

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STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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)	_D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 34	2 915			
	NA-A stated R203 r standing and neede stood up due to bei	really leaned forward when ed to sit down shortly after she ng unsteady. NA-A stated it reeks since R203 had walked				
	to be on a walking p the PT however, the follow was never pu stated she had see walker from the day 10/29/15. At this tim R203. R203 was ob the day room into the observation, RN-a s R203's PT recomm program into the co	5 a.m. RN-A verified R203 was program as recommended by a task directive for the NAs to be tinto the computer. RN-A in R203 walk with one staff and a room to the dining room on the, NA-A was asked to walk proved to slowly walk from the dining room. Following this stated she was going to in-put endation for the ambulation imputer so that the NAs would R203's ambulation each day.				
		range of motion/rehab d on the care plan/nursing l.				
	R65 was diagnosed heart failure and de MDS also indicated was independent in required limited ass Activities of Daily Li dated 9/11/15, indic participating in reharange of motion (Afindicated during the	DS dated 8/31/15, indicated with diabetes, congestive generative joint disease. The R65 had intact cognition and ambulation, bed mobility and sist with dressing. R65's ving Care Area Assessment sated R65 was currently be nursing services for active ROM) and walking. The MDS of MDS reference period R65 days of rehab nursing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 35	2 915			
	1/16/15, indicated F	rapy Plan of care dated R65 had been referred due to ost coronary angiography.				
	refer to R65's resto point click care (PC information. The Reindicated staff were Nu step level 4's 10 three pound ankle wrepetitions seven dawere directed to proand grooming progrand; Red Flex bar sort once and free was seven and	red 8/24/15, directed staff to rative nursing and tasks in a C) for specific program estorative plan dated 8/24/25, to provide R65 ambulation, or minutes and lower extremity weights/kick and march 30 ays per week. In addition staff ovide a restorative dressing ram which was dated ded active ROM on bike 200 20 reps, clothes pin and cord weights for 30 reps. The completed 6 days a week.				
	9/1/15, indicated R6	afety Assessment dated 65 was currently receiving y day to maintain her ability in				
	receiving rehab ser be receiving the ser department was clo and Sunday (11/1/1 and part of Tuesday	a.m. R65 stated she was not vices. R65 stated she was to rvices six days a week and the sed both Saturday (10/31/15) 5) and also Monday (11/2/15) y (11/3/15). R65 stated the lled to work the floor so they ab doors.				
	On 11/5/15, at 8:30	a.m. LPN-F stated there were				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPI	
00298 B. WING 11/00	6/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GRAND VILLAGE 923 HALE LAKE POINTE GRAND RAPIDS, MN 55744	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915 Continued From page 36 days when Rehab was closed due to being short of staff and it was usually on the weekends but verified it also happened on some weekdays. LPN-F stated R65 was very loyal to her rehab program and she did not like to miss it.  On 11/5/15, at 2:08 p.m. rehab aide/TMA-A verified R65's rehab plan directed R65 to attend six days per week but stated R65 would come seven days a week. TMA-A verified R66 had not received services as directed by the care plan as the rehab person had been pulled from the rehab department quite a bit.  The rehab staff schedule was reviewed with rehab aide/TMA-A and the following was revealed:  -10/3/15, no rehab staff, department was closed10/4/15, no rehab staff, department was closed10/6/15, rehab staff julled at 8:30 a.m. to work the floor for the day10/10/15, no rehab staff available, department closed10/13/15, staff was pulled from the department closed10/13/15, rehab staff was pulled from the department and she quit10/18/15, no rehab staff were pulled from the department all day10/29/15, pelhab staff were pulled from the department all day10/29/15, pulled all day10/30/15, pulled all day11/2/15, pulled all day.	

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PRINTED: 12/04/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00298 11/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 923 HALE LAKE POINTE **GRAND VILLAGE** GRAND RAPIDS, MN 55744 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 1 5 Continued From page 37 2 9 1 5 On 11/6/15, at 10:20 a.m. RN-B verified R65 had was to receive rehab / restorative services as directed stated it was more for R65's maintenance and strengthening program which was to be provided six days per week, RN-B confirmed R65's care plan was not being followed. The undated, Restorative Care Policy indicated the objective was directed toward assisting each resident to achieve and maintain their highest level of self-care through positioning, range of motion and ambulation. The policy also indicated the residents' would be assessed at time of admission by PT/OT whereby PT/OT would determine goals and level of restorative care upon discharge from PT/OT therapy services. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures

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regarding the need for assistance with restorative rehabilitative services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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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	
		00298	B. WING		11/0	06/2015	
	PROVIDER OR SUPPLIER	923 HALE	DRESS, CITY, S E LAKE POIN RAPIDS, MN				
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ge 38	2 920				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintain and personal and of This MN Requirements. Based on observation review, the facility fawith oral cares for 2 the sample who we hygiene. In addition perineal cares for 1	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920	Corrected		11/30/15	
	Findings include: R99 did not receive care plan.	oral cares as directed by the					
	(MDS) dated 9/4/15 diagnosed with den disorder. The MDS cognitive impairmen extensive to total as daily living. R99's D (CAA) dated 9/15/1 teeth but was a risk	ange Minimum Data Set 5, indicated R99 was nentia, anxiety and seizure also indicated R99 had nt, had no teeth and required esistance with all activities of rental Care Area Assessment 5, indicated R99 did not have for issues with chewing food, on. The CAA indicated staff					

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
	PROVIDER OR SUPPLIER	923 HALI	DDRESS, CITY, S E LAKE POIN RAPIDS, MN			
(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
2 920	provided R99 oral of using half strength daily.  R99's care plan dat	eares daily and as needed by mouthwash and oral swabs	2 920			
	On 11/5/15, from 7: assistant (NA)-G was morning cares. At offer R99 oral cares -At 7:26 a.m. R99 wroom for breakfastAt 8:50 a.m. NA-H breakfast table to the	10 a.m. until 7:26 a.m. nursing as observed to assist R99 with no time did NA-G provide or				
	were to be complete	a.m. NA-H stated oral cares ed before breakfast. She t offered oral cares after the				
	not offered or provide	a.m. NA-G verified she had ded R99 oral cares and stated ovided oral cares during				
		a.m. registered nurse (RN)-A I have completed oral cares as are plan.				
	R23 was not provid as directed by the c	ed oral cares or perineal cares are plan.				

winneso	<u>ta Department of He</u>	aith				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND \	VILLAGE		LAKE POIN APIDS, MN			
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 40	2 920			
	R23 had dementia, was incontinent of b	S dated 9/29/15, indicated severe cognitive impairment, pladder and required required in all activities of daily living in				
	no teeth and directe twice a day. The pl provide perineal car	red 1/7/15, indicated R23 had ed staff to provide oral cares an also directed staff to res after each incontinent ze protective skin creams.				
	provide R23 with mobserved to be total complete the task as communicate.  -At 6:20 a.m. NA-H assisted NA-G with -At 6:30 a.m. R23 was a wheelchair via a for -At 6:35 a.m. R23 was table.  -At 8:57 a.m. NA-H room to her room. transferred R23 to be -At 9:00 a.m. NA-H check R23's incontibrief was observed NAs removed the bootime during the cobserved to cleanse	vas transferred from the bed to ully body mechanical lift. vas wheeled to the breakfast wheeled R23 from the dining NA-G and NA-I assisted R23 bed. and NA-I were observed to ment brief. R23's incontinent saturated with urine. Both rief and applied a new one. At observations were the NAs e R23's perineal area following ode nor were the NAs				

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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	
		00298	B. WING	<del></del>	11/0	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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
2 920	were to be complete perineal cares were incontinent episode provided R23 oral of directed by the care.  On 11/5/15, at 9:15 not provided R23 or cares.  On 11/5/15, at 9:20 were to have been cares as directed by stated perineal care following each incontinent episode incontinent episode.  The Perineal Care postaff to provide oral lips and oral tissues freshen the resident infections of the modern of Nursing (DON) or evise policies and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignee could educate the staff to provide and provision of oral hydesignees the staff to provide and provision of oral hydesignees the staff to provide and provision of oral hydesignees the staff to provide and provision of oral hydesignees the staff to provide and provision of oral hydesignees the staff to provide and provision of oral hydesignees the staff to provide and provision of oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hydesignees the staff to provide and provision or oral hyde	a.m. NA-H stated oral cares ed before the meal and e to be provided after an a. NA-H verified she had not eares or perineal cares as e plan.  a.m. NA-G verified she had ral cares during morning  a.m. RN-A stated oral cares completed during morning y the care plan. She also es were to be completed intinent episode.  Alicy dated 10/2010, directed cares to ensure the residents is were moist, to cleanse and it's mouth and to prevent outh.	2 920	DETIGIENCITY		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	11/06/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	11/0	0/2010	
GRAND	VILLAGE		LAKE POIN APIDS, MN				
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ge 42	2 920				
	Time Period for Codays.	rrection: Twenty-one (21)					
2 965	5 MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status		2 965			11/30/15	
	Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.						
	by: Based on observation review, the facility for anticipated nutrition supplementation and preference in communication.	ent is not met as evidenced on, interview and document ailed to ensure a resident with all decline received nutritional ecording to the assessed need order to minimize weight loss sidents reviewed for nutrition.		Corrected			
	Findings include:						
	dated 9/4/15, indica severe cognitive im	Minimum Data Set (MDS) ated R203 had dementia and a pairment. The MDS also ghed 149 pounds and required aff while eating.					
	R203's medical rec	ord revealed the following:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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)	D BE	(X5) COMPLETE DATE
2 965		weighed 149 pounds (lbs.) ed 145 lbs. ned 140 lbs.	2 965			
	indicated R203 had on 4-6 ounce house	ogress note dated 10/27/15, a weight loss and was started e or house juice ree times a day between				
	indicated R203 was	order dated 10/27/15, s started on a house s supplement 4-6 ounces three n meals.				
	completed by regist R203's weight was her baseline weight alerted on that date house supplement with the hope R203	ress noted dated 11/3/15, and tered nurse (RN)-A indicated almost 10 pounds less than and R203 was started on a three times a day on 10/27/15, 's weight returned to baseline supplement was never				
	was observed in the R203 consumed se hot chocolate and the	30 a.m. until 8:30 a.m. R203 e dining room eating breakfast. everal bites of toast, a cup of hree ounces of apple juice. y busy talking to herself and ested in eating.				
		a.m. licensed practical nurse was not aware R203 was to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7t. Boilebiiva.			
		00298	B. WING	<del></del>	11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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
2 965	receive a nutritional R203's Treatment A which would have in R203 a supplement indicated R203 was provide R203 a nut stated she had not when she worked the Con 11/5/15, at 11:1 dietitian had written supplement on 10/2 never started because into the computer where the Conference of	I supplement. LPN-A reviewed Administration Record (TAR) dentified the need to provide t, stated the TAR had not is to receive and no directive to ritional supplement. LPN-A provided R203 a supplement ne day shift.  5 a.m. RN-A verified the an order for R203's 27/15, however stated it was use the order was in-putted vrong.  utrition Therapy (MNT), undated, indicated MNT	2 965			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 45	2 965			
	Time Period for Coldays.	rrection: Twenty-one (21)				
21025	MN Rule 4658.0615	5 Food Temperatures	21025			11/30/15
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co	us food must be maintained at heit (four degrees centigrade) grees Fahrenheit (66 degrees e. "Potentially hazardous od subject to continuous time entrols in order to prevent the ve growth of infectious or unisms.				
	by: Based on observati review, the facility for procedures were in maintain appropriat hard boiled eggs which salad cart. The faci appropriate food tento cleaning the protemped. These praraffect all 111 reside	ent is not met as evidenced on, interview and document ailed to ensure appropriate aplemented in order to e holding temperatures of nen served from the resident lity also failed to implement mperature procedures related be in between food items ctices had the potential to nts in the facility who received en and / or salad cart.		Corrected		
	Findings include:					
	Norway dining room	1:				
	was observed in the salad cart. The car	p.m. nursing assistant (NA)-K e Norway dining room with a t was observed to contain a e and several smaller bowls				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
			71. BOILBING.	<del></del>		
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21025	carrots, pickled bees seeds. The cart did the salad toppings of the salad toppings of the salad toppings of the salad toppings of the salad the surveyor approach temperature of the eggs were found to NA-K stated the salad the salad cart contains the dietary staff and the salad cart contains the salad cart contains the salad cart contains the kept cool when salad cart contains remained cooleges from the salad wolf/Moose Lodge  On 11/2/15, at 5:20 Moose / Wolf dining wheeling a salad can ursing staff stated all the residents in the cart was observed to lettuce and several boiled pasteurized of beets, cucumbers at time, cook (C)-A cheggs which measur manager stated states.	iled pasteurized eggs, cheese, ets, cucumbers and sunflower of not have a system to ensure were kept cool prior to service. began to wheel the salad cart asking the residents in the wanted a salad and assisted of their choice. At this time, ached NA-K and requested the boiled eggs be checked. The be 48 degrees Fahrenheit (F). ad cart had been prepared by arrived on the Norway een 4:00 - 4:15. NA-K verified ained boiled eggs which should served and stated the facility em in place to ensure the ol. NA-K removed the boiled di cart.  Dining Room:  p.m. the nursing staff in the groom were observed art into the kitchen. The they had just finished offering the dining room a salad. The to contain a large bowl of smaller bowls that contained eggs, cheese, carrots, pickled and sunflower seeds. At this ecked the temperature of the red 48 degrees F. The dietary of the died 48 degrees F. The dietary of the	21025			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING:			
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		ELAKE POIN RAPIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	Continued From pa	ge 47	21025			
	wheeling a salad ca and several other s larger bowel that we the ice was someth	9 a.m. NA-C was observed art with a large bowel of salad alad items which were set in a as filled with ice. NA-C stated ing new and the kitchen staff with salad items being placed				
	to ensure cold food	ge of Good policy directed staff was maintained at 32-40 ernal thermometer was to be ors and freezers.				
	Woods Dining roon	n:				
	to pick up the food kitchen for the Wood DA-A was observed into the steam table thermometer probe DA-A inserted the pwithout cleaning the same probe into the degrees) Fahrenhe wiped the probe off proceeded to check (195 F) and the swe DA-A rinsed the the running water at the paper towel. DA-A (178 F), followed w F). DA-A wiped the paper towel. DA-A tand wiped the prob	I1:28 a.m. DA-A was observed service tray from the main ods dining room lunch meal. It to place the food containers is DA-A used a yellow food to obtain food temperatures. It to probe into the chicken nuggets is probe first. DA-A inserted the echicken breast (186 it (F) at which time DA-A with a paper towel. DA-A with a paper towel. DA-A is the temperature of the rice is et and sour sauce (195 F). It is ermometer probe under it is es ink and wiped it off with a coroceeded to temp the broccoli it the mashed potatoes (182 thermometer probe off with a remped the hamburger patties is eoff with a paper towel then the gravy (187 F). DA-A				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21025	rinsed the thermomen and wiped off the process cheese (40 F). DAthe thermometer process of the thermometer process of the thermometer probes do that."	neter off under running water robe with a paper towel. DA-A of the lettuce (38 F) and A was not observed to clean tobe between foods.  7 p.m. DA-A stated, " I am wipes to clean the after each food, and I did not p.m. the DM stated food	21025			
	cleanse the thermo food item. However aware some of the proper probe clean have used alcohol between each food wipes came in.  The undated, Clear Thermometers policy	ould have been utilized to meter probe between each r, the DM stated she was neighborhoods were out the sing wipes so staff should wipes to clean the probes in item until the probe cleansing hing Instructions: cy indicated thermometers and sanitized before and after				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for	O Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data a nosocomial infections in a detection, investigation, and so of infectious diseases;	21390			11/30/15

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
004110		923 HALE	LAKE POIN	ITE		
GRAND	VILLAGE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 49	21390			
	reduce risk of trans D. in-service ed prevention and com E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health popractices, including defined in part 4658 G. a system for H. a system for products which affed disinfectants, antise incontinence product. I. methods for a current standards of this MN Requirements.  This MN Requirements.	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and cts; and maintaining awareness of of practice in infection control.		Corrected		
	control standards re protective gloves ar community use glud neighborhoods who glucometers. In add ensure proper hand	o utilized community dition, the facility failed to d hygiene and glove use was ne administration of eye 3 eye medication				
	Findings include:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00298	B. WING		11/0	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 50	21390			
	(LPN)-G was obser caring a glucometer the Norway dining r gloves as she procesugar. Following the placed the glucome returned the glucome medication cart. LF and answered a call no time was LPN-G while completing the	p.m. licensed practical nurse ved to approach R65 while r (blood glucose machine) in oom. LPN-G did not apply eeded to check R65's blood ee blood sugar check, LPN-G eter into a caring basket and neter to the top of the PN-G left the medication cart Il light on the nursing unit. At a observed to apply gloves ee glucose monitoring, sanitize wash her hands after				
	glucometer was util resided on the Norv be cleaned at the e she did not wear glo blood sugar as R65 cares were provided	p.m. LPN-G stated the ized for three residents who vay neighborhood and was to nd of each shift. She verified oves while checking R65's idid not like gloves when d. She verified she did not and did not wash her hands				
		p.m. LPN-M stated the obe cleansed with a ipe after each use.				
		a.m. LPN-H stated the Norway unit was utilized for 5. LPN-H stated the				

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-	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	glucometer was to laddition, LPN-H star gloves while complete R65. She stated at of issues with the siprocedures.  On 11/5/15, at 9:48 stated the staff were the glucometers aft.  Moose / Wolf Lodge.  On 11/2/15, at 4:45 complete R41's bloon to apply gloves as R41's blood sugar. glucometer with an glucometer into a car glucometer to the total complete. LPN-L then wiped the an alcohol wipe, placaring basket and predication cart. At glucometer machineresidents on the Moore with the start of the st	be cleaned after each use. In sted she routinely utilized eting glucose monitoring for no time had R65 had any type taff utilizing gloves during  a.m. registered nurse (RN)-A e to wear gloves and cleanse er each use.	21390			
		a.m. RN-B stated the staff ploves while completing				

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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	
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		923 HALE	LAKE POIN	TE		
GRAND	VILLAGE	GRAND R	APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 52	21390			
		e machines were to be use according to the facility				
	surveyor a paper th Immediately" each own glucometer. Th labeled bag for eac calibrated prior to u who had not yet be	0 a.m. the DON gave the at stated, "Effective resident would be given their ne meter was to stay in a h resident, all meters would be se and nightly. For residents en supplied a personal meter, disinfect the community meter ts with a sani-wipe.				
	Aspen and Birch ne	eighborhood:				
	remove a TrueTRA medication cart. LP test strip, inserted in R38 blood sugar ar of the medication car	a.m. LPN-D was observed to CK glucometer from the N-D obtained a glucometer in the glucometer and obtained individual place the glucometer on topart. LPN-D was not observed leter before or after use.				
	cart and requested tested. LPN-D picket top of the medication into the glucometer glucose and returned the medication cart	opped at LPN-D's medication to have his blood sugar ed up the glucometer from the on cart and inserted a test strip, obtained R61's blood ed the glucometer to the top of LPN-D was not observed to er prior to use or following use.				
	to be cleaned with a	verified the glucometers were a Sani wipe after each use and cleaned the glucometer as				

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she should have.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015
	PROVIDER OR SUPPLIER	923 HALE	E LAKE POIN			
		GRAND F	RAPIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 53	21390			
	glucometer utilized monitoring on the A community glucome clean the machine	4 a.m. RN-B verified the by staff to obtain glucose spen and Birch units was a eter and it was facility policy to after each resident use. RN-B expectation for staff to be policy.				
	neighborhood utilize	a.m. RN-E stated the Spruce ed just one community eter for checking blood sugars				
	At 9:16 a.m. LPN-K stated the Wolf neighborhood had just one community TRUEtrack glucometer used for checking resident blood sugars on this unit.					
	At 10:15 a.m. LPN- neighborhood had j TRUEtrack glucom					
	At 10:30 a.m. LPN- neighborhood had j TRUEtrack glucome sugars.					
	(TMA)-B on the Wa	ed medication assistant ters unit stated her supervisor d sugar checks, however neighborhood had just one ack glucometer.				
	owner's booklet, da important health an WARNING! The TF Monitoring System	cometer manufactures ted 2014 indicated for patients d safety information, RUEtrack Blood Glucose was for one person use only. r Meter or your Lancing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	_	
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	ALL parts of your B System could carry use, even after clea The Blood Sampling policy dated 2014, of the blood glucose in reuse were cleaned resident uses. Sing devises should never resident.  On 11/6/15, at 11:52 TRUEtrack manufa stated "I had no ide used for one persor that last week, and individual lancet per thought to look at the glucometers we are verified the TRUEtr single use was bein on the different unit they were cleaned be concern for the trand diseases. The DON them removed from	ge 54  I, including family members. Ilood Glucose Monitoring blood-borne diseases after aning and disinfection.  Ig - Capillary (Finger Stick) directed staff to always ensure nonitoring meters intended for I and disinfected between Ide-resident use fingerstick er be used by more than one  If an a the glucometers were to be nonly. We had talked about we were planning on going to ns for the residents. I never ne owner's booklet for the er currently using." The DON ack glucometers intended for ng used for multiple residents s in the facility and even if the the council of the service of	21390			
	Eye drops:					
	stop R122 from ent removed R122's gla eye drops in both e	p.m. LPN-G was observed to ering the dining room. LPN-G asses and proceeded to place yes. At no time was LPN-G oves or wash her hands after				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 55	21390			
	installing the eye drops.					
	administered artifications she should have we eye drop medications	p.m. LPN-G stated she had ial tears to R122. She verified orn gloves while administering ns and should have washed ninistering the medication.				
	The Instillation of E directed the staff to administering eye n					
	On 11/6/15, at 8:20 a.m. RN-B stated staff were to utilize gloves and wash their hands after eye medication administration.					
	The director of nurs monitor to assure p related to handwas prevent the spread designee could dev ensure compliance	THOD FOR CORRECTION: sing (DON) or designee could procedures are implemented thing and glove use in order to of infections. The DON or relop a monitoring system to the CAA committee could system to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			11/30/15
	maintain a compret	e provider must establish and nensive tuberculosis ogram according to the most				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/06/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	_	
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implements	s infection control guidelines d States Centers for Disease tion (CDC), Division of lation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, interes. The Department of le technical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to ensi R170, R202, R224) received the tuberc according to the Ce Prevention (CDC) g  Findings include:  RESIDENT TST:  R104 was admitted R104's electronic m (MAR) indicated R1 on 10/13/15, and th	and document review, the ure 4 of 5 residents (R104, and 1 of 5 employees (NA-J) ulin skin testing (TST) enters for Disease Control and guidelines.  to the facility on 10/12/15. nedical administration record 04 received the first step TST is test was read as negative nm) induration on 10/14/15		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	11/0	0/2013
GRAND	VILLAGE		LAKE POIN			
0/0.15	CLIMMA DV CTA	GRAND R TEMENT OF DEFICIENCIES	APIDS, MN		ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
21426	Continued From pa	ge 57	21426			
	(one day later). (CI reaction should be after administration received the second test was read as not the record failed to induration and CDC	DC guidelines include skin test read between 48 and 72 hours) R104's MAR indicated R104 d step TST 10/26/15, and this egative on 10/28/15. However, indicate millimeters of guidelines include: exact aduration (if no induration,				
	R170's MAR indica step TST on 6/10/1 negative on 6/12/15 the millimeters of in indicated R170 rece 10/26/15, and this t	to the facility on 6/10/15. ted R170 received the first 5, and this test was read as 6. The MAR failed to indicate iduration. R170's MAR eived the second step TST est was read as negative on rd failed to indicate millimeters				
	R202's MAR indica step TST on 9/1/15 negative on 9/3/15. received the second test was read as ne	to the facility on 8/31/15. ted R202 received the first , and this test was read as R202's MAR indicated R202's d step TST 9/15/15, and this egative on 9/17/15. The record Illimeters of induration.				
	R202's MAR indica step TST on 10/16/ negative on 10/17/1 recommended 48-7 indicated R224's re 10/29/15, and this t	to the facility on 10/15/15. ted R202 received the first 15, and this test was read as 5 (one day later instead of the 72 hours). R224's MAR ceived the second step TST est was read as negative on rd failed to indicate millimeters				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21426	Continued From pa	ge 58	21426			
	EMPLOYEE TST:					
	10/27/15. NA-K's were completed at administration form first step of her TST read on 8/10/15, wi NA-K received the This test was read	It (read the same day it had				
	On 11/5/15, at 11:30 the director of nursing (DON) confirmed the results of resident's TST were not documented accurately. The DON stated the staff were directed to document the millimeters of induration and if there is no induration the record needs to indicate 0 induration.					
	nurse verified 4 of t	p.m. the quality coordinator he 5 residents reviewed had entation, the results were noted did not indicate the millimeters				
	NA-K's TST admini	0 a.m. the DON verified stration form indicated the n and read on the same day e been.				
	The facility's Tubero	culosis Prevention and Control				

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policy dated 12/12, indicated all residents would

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALL ELAKE POINTE  GRAND VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES GRAND RAPIDS, MN 55744  PREFIX TAG  PREFIX TAG  COMPLETE TAG  CONTINUED FROM USST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PROVIDERS PLAN OF CORRECTION TAG  PROVIDERS PLAN OF CORRECTION TAG  CROSS REFERENCED TO THE APPROPRIATE  CROSS REFERENCED TO THE APPROPRIATE  DEFICIENCY DATE  DATE  CROSS REFERENCED TO THE APPROPRIATE  DATE  CROSS REFERENCED TO THE APPROPRIATE  CROSS REFERENCED TO THE APPROPRIAT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
CRAND VILLAGE   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   CACH CORRECTION   PREFIX TAG   CACH CORRECTION   CACH CORRECTIVE ACTION SHOULD BE COMPLETE   CACH CORRECTIVE ACTION SHOULD BE CACH CACH CACH CACH CACH CACH CACH CAC			00298	B. WING		11/0	6/2015
XM   ID   SUMMAY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG)	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  21426  Continued From page 59 receive a baseline TB screening within 72 hours of admission. The baseline TB screening within 72 hours of admission. The baseline TB screening consisted of assessing the resident's risk factors for TB, assessing for current symptoms of active TB disease and testing for the presence of infection by administering the two step TST. Written documentation (including the dates and results) of all pertinent TB testing and evaluations will be easily accessible in the resident's medical record.  The facility policy also indicated all health care workers would be will be tested for TB prior to employment. The policy indicated baseline TB screening at the time of hire is required for all health care workers in Minnesota and consists of two components, assessing for current symptoms of active TB disease and testing of the presence of infection by administering a two-step TST. At time of reading:  Name and signature of person reading test Date and time test read Exact number of mm of induration (if no induration, document "0" mm) Interpretation of reading (i.e., positive or negative, based on individual's risk factors) SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could provide education for staff regarding resident and staff tuberculosis screening and testing. The DON and/or designee could do random audits to ensure compliance.	GRAND	VILLAGE		_			
receive a baseline TB screening within 72 hours of admission. The baseline TB screening consisted of assessing the resident's risk factors for TB, assessing for current symptoms of active TB disease and testing for the presence of infection by administering the two step TST. Written documentation (including the dates and results) of all pertinent TB testing and evaluations will be easily accessible in the resident's medical record.  The facility policy also indicated all health care workers would be will be tested for TB prior to employment. The policy indicated baseline TB screening at the time of hire is required for all health care workers in Minnesota and consists of two components, assessing for current symptoms of active TB disease and testing of the presence of infection by administering a two-step TST. At time of reading:  Name and signature of person reading test Date and time test read Exact number of mm of induration (if no induration, document "0" mm) Interpretation of reading (i.e., positive or negative, based on individual's risk factors) SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could provide education for staff regarding resident and staff tuberculosis screening and testing. The DON and/or designee could do random audits to ensure compliance.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
	21426	receive a baseline of admission. The consisted of assess for TB, assessing for TB disease and tes infection by administ Written documentation results) of all pertine will be easily access record.  The facility policy all workers would be well workers would be well workers would be well workers would be well workers workers two components, as of active TB disease of infection by admining the components o	TB screening within 72 hours be be considered all health care will be tested for TB prior to colicy indicated all health care will be tested for TB prior to colicy indicated baseline TB and testing of the presence of the in the resident's medical and the interpretation of the presence of the interpretation of the presence of the interpretation of the prior to colicy indicated baseline TB are of hire is required for all and testing of the presence of the pres	21426			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LETED
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN			
	T		APIDS, MN			ı
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 60	21530			
21530	0 MN Rule 4658.1310 A.B.C Drug Regimen Review		21530			11/30/15
	reviewed at least m currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Mealth Care Finance This standard is incompared available through the system. It is not sure B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For purpon' means the acreport and the signification of nursing services. C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely affer fer the matter to the attending physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct control of the medica	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next poner, if indicated by the proses of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. In ing physician does not concurts recommendation, or does the justification, and the steeted, the pharmacist must he medical director for review for is not the attending edical director determines that coin does not have adequate order and if the attending change the order, the matter is review to the quality surance committee required of the attending physician is or, the consulting pharmacist er directly to the quality				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00298	B. WING		11/0	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21530	Continued From pa	ge 61	21530			
	assessment and assurance committee.					
	by: Based on interview facility consultant plus sleep patterns were	ent is not met as evidenced and document review, the harmacist failed to ensure e identified and monitored in sleep medication		Corrected		
	order to determine sleep medication effectiveness and failed to ensure non pharmacological interventions had been identified and implemented prior to the use of hypnotic (for sleep) medication for 1 of 1 resident (R203) who received daily medication for sleep.					
	Findings Include:					
	9/4/15, indicated R2 cognitive impairment assist for mobility, c D0200 of the MDS	Minimum Data Set MDS dated 203 had dementia with severe nt and required extensive staff dressing and toileting. Section did not indicate R203 had any aying asleep or sleeping too				
	identification of insolindividualized inson the care plan lacked non-pharmacologic before the administ R203's Nursing Ass	ated 9/17/15, lacked omnia or monitoring of nnia symptoms. In addition, d evidence that all approaches were tried tration of the medication. Sistant (NA) care plan did not armacological interventions to				
	R203's current phys	sician's orders dated 10/12/15,				

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Minneso	<u>ita Department of He</u>	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/0	6/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRAND	VILLAGE		LAKE POIN APIDS, MN				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 62	21530				
		minister Trazodone HCL tablet bed time for insomnia.					
		rmacist November 2015, ess R203's usage of o.					
	verified R203 received sleeping. RN-A state sleep study assess after the medication stated there was not note related to the reactions from the record. In addition, plan lacked any independent received medication pharmalogical interesigns / symptoms of for. RN-A confirmed	3 a.m. registered nurse (RN) ved Trazadone due to not ted she did not complete a ment prior the initiation of or n was administered. RN-A also o documentation or summary effectiveness or adverse medication in R203's medical RN-A verified R203's care lication R203 had insomnia, n to induce sleep, non eventions to be attempted or of adverse reactions to monitor d the consulting pharmacist r addressed R203's sleep.					
	undated, indicated reviewed the medic monthly. The consuincluded evaluating	n Review (Monthly Report), the consultant pharmacist cation regimen of each resident ultant pharmacist's evaluation indications for use of a nonitoring was being nedication and					

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SUGGESTED METHOD OF CORRECTION:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING	<del></del>	11/0	6/2015
	PROVIDER OR SUPPLIER	923 HALE	DRESS, CITY, S LAKE POIN APIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	The director of nurse consulting pharmace monitor residents remedications and as use are identified. To committee could recontinued complian	sing or designee and the sist could establish a system to eceiving antipsychotic sure adequate indications for The quality assurance view the process to ensure	21530			
21540	Subp. 2. Monitoring monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is a the medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician physician does not the director and if the change the order, the attending physician director and if the change the order, the attending physician director and if the change the order, the attending physician director and if the change the order, the attending physician director and if the change the order, the attending physician director and the change the order and the attending physician director and the change the order and the change th	g. A nursing home must ent's drug regimen for usage, based on the nursing I procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nust refer the all director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not not matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter	21540			11/30/15

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				<del> </del>		
		00298	B. WING		11/0	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 64	21540			
	by: Based on observati review the facility fa comprehensive slee monitoring was con non- pharmacologic to the administration	ep assessment and sleep repleted and failed to identify cal interventions for sleep prior n of a hypnotic (used for idents (R203) reviewed for		Corrected		
	9/4/15, indicated R2 cognitive impairment assist for mobility, c D0200 of the MDS	Minimum Data Set MDS dated 203 had dementia with severe at and required extensive staff dressing and toileting. Section did not indicate R203 had any sying asleep or sleeping too				
	identification of inso individualized inson the care plan lacked non-pharmacologic before the administ R203's Nursing Ass	ated 9/17/15, lacked omnia or monitoring of nnia symptoms. In addition, d evidence that al approaches were tried ration of the medication. sistant (NA) care plan did not armacological interventions to				
	directed staff to adr	sician's orders dated 10/12/15, ninister Trazodone HCL tablet bed time for insomnia.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00298	B. WING		11/0	6/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE			
GRAND VII I AGE	LAKE POINT APIDS, MN 5				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21540 Continued From page 65  On 11/5/15, at 5:55 a.m. R203 was observed in bed, asleepAt 6:00 a.m. NA-A and NA-B were observed to transfer R203 from bed into the wheelchair, wheel R203 to the dining room and provide R203 with a cup of coffeeAt 7:40 a.m. R203 was observed eating independently.  On 11/5/15, at 11:43 a.m. registered nurse (RN) verified R203 was on Trazadone due to not sleeping. RN-A stated she did not complete a sleep study assessment prior the initiation of or after the medication was administered. RN-A also stated there was no documentation or summary note related to the effectiveness or adverse reactions from the medication in R203's medical record. In addition, RN-A verified R203's care plan lacked any indication R203 had insomnia, received medication to induce sleep, non pharmalogical interventions to be attempted or signs / symptoms of adverse reactions to monitor for.  A policy on conducting sleep studies was requested however, no policy was received.  A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related medication monitoring. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.	21540	DELICITION OF THE PROPERTY OF			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING		11/06/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND VILLAGE			LAKE POIN APIDS, MN			
(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 APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 66	21540			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			11/30/15
	Drugs used in the nursing home must be labeled in accordance with part 6800.6300.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled and dated when opened for 1 of 6 residents (R122) whose medications were observed for medication storage. In addition, the facility failed to ensure expired stock Aplisol (serum protein derivative used to test for tuberculosis infection) was discarded after being opened greater than 30 days. This had the potential to affect all new admission on 1 of 4 units (Cedar) and newly hired staff.			Corrected		
	Findings include:					
	vial of Aplisol was of medication storage "open date" of 8/21. Review of the JHP (manufacturer of Apguidelines for storage days should be discoxidation and degrapotency." Licensed	a.m. an opened multi-dose bserved in the Cedar wing room refrigerator with and /15, handwritten on the label. Pharmaceuticals, LLC blisol) included the following ge: "Vials in use more than 30 carded due to possible adation which may affect practical nurse (LPN)-E was observation and confirmed the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GRAND	GRAND VILLAGE 923 HAL GRAND					
(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)	_D BE	(X5) COMPLETE DATE
21620	Aplisol serum had be days and should haw was not used.  -At 9:04 a.m. R122 stored in the medicopened, used and ulumigan eyedrops wasted the medicatic confirmed the bottle LPN-E reported the eye doctor, therefore indicating who their directions for admire yedrop medication opened and all medication refrigera (LPN)-F stated it she gave the expired Applisol vial remainer medication refrigera (LPN)-B for destruct On 11/5/15, at 6:41 medications should and stated the facili order and obtained lumigan eye drops. medication should the Aplisol should hexpired, 30 days af On 11/5/15, at 2:29 (DON) indicated states.	been open greater than 30 ove been discarded to ensure it as Alphagan eye drops were ation cart was observed undated. An unlabeled bottle of was also observed. LPN-E on belonged to R122, and elacked a pharmacy label. It medication came from the re, did not have a label medication belonged to or histration. LPN-E confirmed all his should be dated when dications should have a lacked.  So a.m. the same expired and in the Cedar wing lator. Licensed Practical Nurse lould have been destroyed and olisol to Registered Nurse	21620			

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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	
		00298	B. WING		11/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE		
GRAND	VILLAGE		E LAKE POIN RAPIDS, MN			
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 68	21620			
		bel attached unless it was nd confirmed the Aplisol lisposed of.				
	A policy regarding n requested but not p	nedication storage was rovided.				
	The director of nurs and revise the polic the dating, and labe expired medications provide education to could develop a mo	ETHOD FOR CORRECTION: sing or designee could review ies and procedures related eling and destruction of s. The DON or designee could or all involved staff. The facility enitoring system to ensure er and report the findings to the Committee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21685	MN Rule 4658.1418 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			11/30/15
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by:	ent is not met as evidenced on, interview and document		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN OF CORNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	LETED
	00298 B. WING		11/06/2015		
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND VII I AGE		LAKE POIN APIDS, MN			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
armrests, resident were maintained for 1 of 2 resident uncleanable arm R55) in Lakes neituse of a mechani (R25) who utilized facility failed to prenvironment in retrooms (213, 215, were observed to attached to equip Lastly, the facility kitchen food storate clean and sanitary.  Findings include:  R23's wheelchair uncleanable and cleanable foam properties of the company of the co	failed to ensure wheelchair to mechanical lifts and a lap tray in a clean and sanitary conditions (R23) who had torn, rests, for 2 of 2 residents (R23, ghborhood who required the cal lift and for 1 of 1 resident. If a lap tray, In addition, the covide a clean and sanitary sident rooms for 7 of 7 resident and 10, 418, 423, 426,413) which have uncleanable surfaces ment and room furnishings. If alled to ensure the kitchen and age areas were maintained in a manner.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.  The armrests were torn and the mechanical lift had non adding attached to it.	21685	BEI IGIENOT)		

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MAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALE LAKE POINTE GRAND VILLAGE  923 HALE LAKE POINTE GRAND RAPIDS, MN 55744  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST BE PRECEDED BY FILL) FREEIX TAG  CROSS-REFERENCE OT THE APPROPRIATE  21685  Continued From page 70  and NA-H were observed to transfer R23 into the wheelchair via a full body EZ mechanical lift. The hydraulic portion of the lift moved the arm of the lift which held the sling / resident during the transfer. The lower portion of the hydraulic bar had a porous black foam piece wrapped around it and secured with black adhesive tape. The tape was peeling away from the foam. The center of the sling strap be awas also observed to have foam padding added to prevent the resident from hitting their head on the bar. NA-H stated the lift was utilized for R23 an R55. R23's wheelchair armrests were observed torm approximately 4-6 inches on both sides of the arm rest with the foam padding exposed. The arm rest with the foam padding exposed. The arm rests and the mechanical lift were uncleanable.  On 11/5/15, at 6:30 a.m. NA-H stated R23's arm rests had been torn for a long time. NA-H stated R23's family had applied tape to them in the past to make them smoother, but the tape had been removed.  Review of the EZ Lift manufactures manual dated 9/2008, did not include directions or suggestions related to the addition of foam padding to the machines.  On 11/5/15, at 10:55 a.m. maintenance staff ME) A stated by did not include directions or suggestions related to the addition of foam padding to the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALE LAKE POINTE GRAND RAPIDS, MN 55744  (X4) ID PREFEIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM USC IDENTIFYING INFORMATION)  21685  Continued From page 70  and NA-H were observed to transfer R23 into the wheelchair via a full body EZ mechanical lift. The hydraulic portion of the lift moved the arm of the lift which held the sling / resident during the transfer. The lower portion of the hydraulic bar had a porous black foam piece wrapped around it and secured with black adhesive tape. The tape was peeling away from the foam. The center of the sling strap bar was also observed to have foam padding added to prevent the resident from hitting their head on the bar. NA-H stated the lift was utilized for R23 an R55. R23's wheelchair armrests were observed torn approximately 4-6 inches on both sides of the arm rests and the mechanical lift were uncleanable.  On 11/5/15, at 6:30 a.m. NA-H stated R23's arm rests had been torn for a long time. NA-H stated R23's family had applied tape to them in the past to make them smoother, but the tape had been removed.  Review of the EZ Lift manufactures manual dated 9/2008, did not include directions or suggestions related to the addition of foam padding to the machines.  On 11/5/15, at 10:55 a.m. maintenance staff			00000			44 (0	0/0045
CRAND VILLAGE   SUMMARY STATEMENT OF DEFICIENCIES   CRAND RAPIDS, MN 55744						11/0	6/2015
CKAI   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (CROSS-REFERENCE) TO THE APPROPRIATE   CONFIDENCIAL PREGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE TAG   TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE DATE    21685   Continued From page 70   21685   Continued From page 70   and NA-H were observed to transfer R23 into the wheelchair via a full body EZ mechanical lift. The hydraulic portion of the lift moved the arm of the lift which held the sling / resident during the transfer. The lower portion of the hydraulic bar had a porous black foam piece wrapped around it and secured with black adhesive tape. The tape was peeling away from the foam. The center of the sling strap bar was also observed to have foam padding added to prevent the resident from hitting their head on the bar. NA-H stated the lift was utilized for R23 an R58. R23's wheelchair armrests were observed torn approximately 4-6 inches on both sides of the arm rest with the foam padding exposed. The arm rests and the mechanical lift were uncleanable.  On 11/5/15, at 6:30 a.m. NA-H stated R23's arm rests had been torn for a long time. NA-H stated R23's family had applied tape to them in the past to make them smoother, but the tape had been removed.  Review of the EZ Lift manufactures manual dated 9/2008, did not include directions or suggestions related to the addition of foam padding to the machines.  On 11/5/15, at 10:55 a.m. maintenance staff	NAME OF	PROVIDER OR SUPPLIER					
CALID   SUMMARY STATEMENT OF DEFICIENCIES   PRICE   PRICE	GRAND	VILLAGE					
and NA-H were observed to transfer R23 into the wheelchair via a full body EZ mechanical lift. The hydraulic portion of the lift moved the arm of the lift which held the sling / resident during the transfer. The lower portion of the hydraulic bar had a porous black foam piece wrapped around it and secured with black adhesive tape. The tape was peeling away from the foam. The center of the sling strap bar was also observed to have foam padding added to prevent the resident from hitting their head on the bar. NA-H stated the lift was utilized for R23 an R55. R23's wheelchair armrests were observed torn approximately 4-6 inches on both sides of the arm rest with the foam padding exposed. The arm rests and the mechanical lift were uncleanable.  On 11/5/15, at 6:30 a.m. NA-H stated R23's arm rests had been torn for a long time. NA-H stated R23's family had applied tape to them in the past to make them smoother, but the tape had been removed.  Review of the EZ Lift manufactures manual dated 9/2008, did not include directions or suggestions related to the addition of foam padding to the machines.  On 11/5/15, at 10:55 a.m. maintenance staff	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
(MS)-A stated he did not know when the foam padding was added to the mechanical lift. He verified the foam padding and adhesive tape did not create a cleanable surface and was not a recommended interventions from the	21685	and NA-H were obswheelchair via a ful hydraulic portion of lift which held the stransfer. The lower had a porous black and secured with blwas peeling away fithe sling strap bar vifoam padding adde hitting their head or was utilized for R23 armrests were obscinches on both side foam padding expomechanical lift were on the stransfer of the EZ L3 (S) family had apto make them smoot removed.  Review of the EZ L3 (S) family had apto make them smoot removed.  Review of the EZ L3 (S) (S) A stated he dipadding was added verified the foam panot create a cleanal stransfer of the stransfe	served to transfer R23 into the I body EZ mechanical lift. The the lift moved the arm of the ling / resident during the portion of the hydraulic bar foam piece wrapped around it ack adhesive tape. The tape rom the foam. The center of was also observed to have d to prevent the resident from a the bar. NA-H stated the lift an R55. R23's wheelchair erved torn approximately 4-6 as of the arm rest with the sed. The arm rests and the e uncleanable.  a.m. NA-H stated R23's arm for a long time. NA-H stated explied tape to them in the past other, but the tape had been lift manufactures manual dated added directions or suggestions on of foam padding to the adding and adhesive tape did ble surface and was not a	21685	DEFICIENCY		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GRAND	GRAND VILLAGE 923 HAL GRAND					
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	replaced. He stated sent a work request so the repair could stated he would report R25's wheelchair lactean and sanitary restraint to prevent was in place.  R25's care plan dat was to have wheeld	d nursing staff should have t to the maintenance director have been completed. MS-A place the arm rests.	21685			
	seated in the wheel with NA-K assisting The lap tray is observed to have a piece taped on with 20 inch edge of the -At 8:54 a.m. NA-K NA-K verified food also on the black fo NA-K stated the edge the foam was applied leaned forward the against his stomach now how often the followed cleaned any other walso stated she did	a.m. R25 was observed chair, in the Woods dining him with the breakfast meal. erved in use. The tray was three inch black porous foam two inch clear tape, along the tray next to R25's abdomen. assisted R25 to his room. debris was on the tray and am. NA-K wiped the tray off. ge of the tray was sharp so ed for cushion so when R25 edge of the tray did press a. NA-K also stated she did not foam was changed or if it was way than wiping it off. NA-K not know how long it had been ed it off when it was dirty.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN APIDS, MN			
(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)	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 72	21685			
	his wheelchair, asledebris on the tray and adhesive tape. At the was dirty and the form of surface. RN-B states and staff were committee tray out and repland cleanable.  On 11/6/15, at 2:10 (DON) verified R25 the tray with the blan of a cleanable and stated staff were we foam that was attack replace it with an adstated the facility dieserge and the stated the facility dieserge.	2:53 p.m. R25 was observed in sep. R25's lap tray has food and on the black foam and his time, RN-B verified tray sam was an uncleanable and R25 needed the lap tray sing up with a plan to change place it with one that was safe p.m. the director of nursing stray was needed, however, ck porous foam adhered was a sanitary surface. The DON orking towards removing the shed to the equipment and coeptable option. The DON do not have a policy related to padding or for cleaning it.				
	ENVIRONMENT:					
	of the facility was co	0:45 am until 11:27 a.m. a tour ompleted with the director of l) and the DOM verified the				
	inch black porous for taped on with two in raveling and had dr was observed to hat by 10 inch wide black taped to the pipe or the toilet seat.	bilateral bed rails had three cam attached to the rails and nch black tape which was ied debris on it. The bathroom we a half inch by 14 inch long ck porous foam tape was in the back of the toilet, behind bilateral side rails had three				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	06/2015
	PROVIDER OR SUPPLIER	923 HALE	LAKE POIN			
			APIDS, MN	55744		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	Continued From pa	ae 73	21685			
	inch black porous for two inch black tape bathroom toilet was 14 inch long by 10 i porous foam taped toilet, behind the toi	pam attached and taped with which was raveling. The observed to have half inch by nch wide sheet of black to the pipe on the back of the				
	inch black porous fo	pam attached and secured tape which was raveling and				
	-Room 413's upper bilateral side rails had three inch black porous foam attached and secured with two inch black tape.					
	inch black porous for with two inch black	bilateral side rails had three bam attached and secured tape which was raveling and tape has dried debris on it.				
	black tape and two inch section over th The grab bar attach had 24 inch by three	oom door frame had two inch inch duct tape covering an 18 e door latch, frame section. ned to wall next to the toilet e inch black porous foam ed with black tape. The tape ad debris on it.				
	the foam to all of th facility did not have The DOM stated he removed and clean foam. The DOM sta schedule for chang the facility had neve infection risks or the verified the foam wa	ne maintenance staff applied e identified areas and the a cleaning policy for the foam. e did not think anyone ed the backsides or under the ated the facility did not have a ing the foam. The DOM stated or thought of the safety part of e cleaning process. The DOM as not cleanable and stated arted to remove the foam.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015
	NAME OF PROVIDER OR SUPPLIER  GRAND VILLAGE  GRAND  GRAND					
(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)	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 74	21685			
	KITCHEN:					
		8 p.m. a tour of the kitchen the dietary manager (DM) as observed:				
	kitchen floor area we debris and a black/g food/black/gray debthe stove, under the and alongside and leading machine. In addition was observed to ha gray debris build upperimeter of the floor observed under the The DM verified the sanitary and stated and deep cleaning of	th perimeter of the entire ras observed to have food gray debris build up on it. The oris was also observed behind a food preparation counters behind the food steam in, the dry food storage area ave food particles and black o around the outer eight inchor. The debris was also wire food storage shelving. It floors were not clean and staff were assigned cleaning duties. The DM stated the in and staff were not cleaning is directed to do so.				
	03/05, indicated reg daily, weekly and m food service area w policy indicated dail floors, sweep and n	Cleaning Schedule" dated gular cleaning was scheduled onthly to ensure that all of the ras washed and sanitized. The y tasks included cleaning the nop including the dry storage counters, fridges, cabinets and				
	SUGGESTED MET	HOD OF CORRECTION:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,			(X3) DATE COMP	SURVEY LETED
		00298	B. WING		11/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	GRAND VILLAGE 923 HAL GRAND					
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	The director of nurs and revise policy ar equipment mainten and cleaning proce of nursing or design education and develors are ongoing cor The Dietary Manag develop, review and procedures to ensure kitchen. The DN all appropriate staff	sing or designee could review and procedures related to ance, reporting procedures dures / surfaces. The director nee could provide staff alop a monitoring system to impliance.  er (DM) or designee could down revise policies and re a sanitary environment in of or designee could educate on the policies/procedures, monitoring systems to ensure es.	21685			
21995	Maltreatment of Vul Subd. 4a. Interna (a) Each facility sho ongoing written pro applicable licensing of suspected maltre facility has an internal mandated reporter requirements of this internally. However responsible for com- reporting requirements. This MN Requirements by: Based on interview facility failed to imm	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting as section by reporting r, the facility remains aplying with the immediate	21995	Corrected		11/30/15

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00298	B. WING	B. WING		6/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
GRAND	VILLAGE		LAKE POIN			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	possible mistreatme misconduct for 1 of and for 1 of 2 reside involved with potent Findings include:	ent related potential sexual 3 incident reports reviewed ents (R148, R145) who were tial sexual misconduct.	21995			
	R148's quarterly Minimum Data Set (MDS) dated 9/25/15, indicated R148 was diagnosed with dementia, anxiety disorder, depression and seizure disorder. The MDS also indicated R148 had severe cognitive impairment, required extensive assist for activities of daily living and supervision - limited assistance of one staff while ambulating. The MDS also indicated R148 displayed physical aggression towards other 1-3 days and wandering behaviors 4-6 days during the MDS assessment period.					
	Assessment (CAA) R148 was able to a	es of Daily Living Care Area dated 12/29/14, indicated mbulate independently without e device and she was at risk				
	R148 was diagnose risk for further cogn progression. R148	AA dated 12/29/15, indicated ed with dementia and was at litive decline due to disease had difficulty communication ers and the staff were to s.				
	was at risk for falls,	ated 12/26/14, indicated R148 wandered throughout the s unable to remove herself				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00298		00298	B. WING		11/06/2015		
NAME OF PROVIDER OR SUPPLIER  STREET ADI  923 HALE			DDRESS, CITY, STATE, ZIP CODE  E LAKE POINTE  RAPIDS, MN 55744				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21995	intervene and sepa concerns were iden alone with R145 an safe. R145's quarterly MI	re plan directed staff to rate resident as safety stiffied, to ensure R148 was not d to keep the environment	21995				
	R145 was diagnosed with chronic obstructive pulmonary disease and had moderate cognitive impairment. The MDS indicated R145 required extensive assistance with activities of daily living and had not displayed dementia or mood/behavior indicators.						
	R145's care plan dated 3/31/15, identified a concern related to R145 attempting to have intimacy / courtship behaviors directed towards female residents residing in the community. The goal was to prevent courtship behaviors with the unidentified female resident as it was "nonconsensual."						
	Review of R148's P following:	rogress Notes revealed the					
	Rivers Community resident with demendown R148's pants separated the residu continue to monitor intervene as necess complete an incider	5 p.m. R148 was found in the seated next to R145 (a male ntia). R145 had his hand. The staff members ents and directed the staff to R148's whereabouts and sary. The facility did not nt report, complete a thorough ported it to the State Agency,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00298	B. WING		11/0	6/2015	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  923 HALF LAKE POINTE						
GRAND	/ILLAGE	GRAND R	APIDS, MN	55744			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21995	stated R148 had incomplete stated shother resident room that did not belong its staff kept an eye on FM-A did not expressinappropriate sexual Cn 11/4/15, at 12:44 (LPN)-I stated R148 Neighborhood and altercations with other when that happeness separated. LPN-I st concerns with the resperated. She should be separated. She should be separated. She should be separated. She should be separated. She should be separated incidences.  On 11/4/15, at 1:02 stated R148 continuon the unit. AA-A st disrupted other resis R148 wandering, should be should	O p.m. family member (FM)-A creased wandering in the past ne was aware R148 entered as and often picked up items to her. She stated the facility R148 as best as possible. It is any concerns related to all touch.  B p.m. licensed practical nurse wandered around the Lakes at times would have ner residents. She stated do the residents were atted if she had noticed esidents, the residents would estated she was aware of R148 resident to resident do not observed any of the p.m. activity aide (AA)-A uously wandered and paced atted she did not feel R148 dents and when she noticed ne tried to engage R148 in a p.m. nursing assistant (NA)-H	21995				
	stated R148 wande did not seem to be residents nor did the afraid of R148. She residents if she saw	red daily. She stated R148 afraid of any of the other e other residents seem to be e stated she separated the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00298	B. WING		11/06/201			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GRAND	GRAND VILLAGE  923 HALE LAKE POINTE  GRAND RAPIDS, MN 55744							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21995	(LSW)-A stated she any concerns related concerns on the La was unaware of any taken place.  On 11/5/15, at 12:0 (RN)-A stated the a occurred with other therefore, the reside and separated. She were decreased who dementia care units had not attempted to decreased the behavesidents (R145). If put any other intervities supervision on the Lakes Neigh decrease resident to the supervision on the Lakes Neigh decrease resident to the supervision of the Lakes Neigh decrease resident	e had not been made aware of ed to resident to resident kes Neighborhood. Therefore, y investigations that may have  6 p.m. registered nurse litercations involving R148 residents with dementia ents were just to be observed e stated R148's behaviors are the doors between the two is were closed because R148 to open the doors which aviors with some of the male RN-A stated the facility had not entions in place to increase the Lakes Neighborhood.  4 p.m. LSW-A stated the eased staffing or supervision borhood in an attempt to o resident altercations and ety. LSW-A stated the only plemented was to close the	21995					
	The undated Abuse	Prevention Plan directed staff						

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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21995 Continued From page 80  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21995	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED		
GRAND VILLAGE  923 HALE LAKE POINTE GRAND RAPIDS, MN 55744  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21995  Continued From page 80  923 HALE LAKE POINTE GRAND RAPIDS, MN 55744  ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21995			00298	B. WING		11/0	6/2015		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)    Comparison of the prescription	NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21995 Continued From page 80  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMING DEFICIENCY)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMING DEFICIENCY)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMING DEFICIENCY)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMING DEFICIENCY)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMING DEFICIENCY)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMING DEFICIENCY)	GRAND	GRAND VILLAGE							
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE		
to immediately report all suspected maltreatment / mistreatment to the State Agency. The plan indicated resident to resident altercations would be reportable if the residents acted "wilffully."  On 11/5/15, at 2:05 p.m. LSW-A stated the facility was to report any concerns related to resident to resident potential sexual misconduct if the residents were seeking each other out. LSW-A stated R148 and R145 had sought each other out as they were not involved with sexual misconduct with any other residents. LSW-A verified the incident as noted above should have been investigation and reported to the State Agency as directed by the policy.  SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the reporting/investigating process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated.  TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21995	to immediately report / mistreatment to the indicated resident to be reportable if the On 11/5/15, at 2:05 was to report any coresident potential so residents were seed stated R148 and R as they were not inwith any other resident as noted all investigation and redirected by the policity of the reporting/invest maltreatment. The services or designed all appropriate staff procedures. The acceptable of abuse investigated.	ort all suspected maltreatment be State Agency. The plan or esident altercations would residents acted "willfully."  p.m. LSW-A stated the facility oncerns related to resident to exual misconduct if the king each other out. LSW-A 145 had sought each other out volved with sexual misconduct dents. LSW-A verified the bove should have been exported to the State Agency as cy.  THOD FOR CORRECTION: DON, social services or review and revise as sies and procedures regarding igating process of abuse or administrator, DON, social see (s) could provide training for fron these policies and dministrator, DON, social see (s) could monitor to assure are being reported and	21995	DELIGITION 1				