DEPARTMENT OF HEALTH					CENTERS FOR ME	DICARE & MEDIC	CAID SERVICES
					AND TRANSMITTAL		D: 477C
1. MEDICARE/MEDICAID PROVIDE		3. NAME AND AI	DDRESS OF FAC	CILITY	TE SURVEY AGENCY	4. TYPE OF ACTIO	Facility ID: 00989 N: <u>7</u> (L8)
(L1) 245097 2.STATE VENDOR OR MEDICAID N (L2) 332668000	0.	 (L3) FARIBAUL? (L4) 1738 HULE' (L5) FARIBAUL? 	TT AVENUE N		(L6) 55021	 Initial Termination Validation 	 Recertification CHOW Complaint
5. EFFECTIVE DATE CHANGE OF C (L9) 01/01/2011 6. DATE OF SURVEY 05/02	WNERSHIP 5/2014 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	JPPLIER CATEG 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 8. Full Survey After FISCAL YEAR ENDE	
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/III 12 RHC	D 15 ASC 16 HOSPICE	12/31	NO DATE. (L33)
11LTC PERIOD OF CERTIFICATION	ſ	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	f The Following Requirem	ents:
To (b):			equirements e Based On:		2. Technical Personnel		
12. Total Facility Beds	55 (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural S! 5. Life Safety Code	 Medical Dir 7. Medical Dir 8. Patient Roon 9. Beds/Room 	n Size
13.Total Certified Beds	55 (L17)	B. Not in Con Requirement	npliance with Prog ents and/or Appli	gram ed Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 55	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Susanne Reuss, Supervisor		(05/21/2014	(L19)	Anne Kleppe, Enforce	ement Specialist	06/09/2014 (L20)
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	, ,	L OFFICE OR SINGLE S	STATE AGENCY	(L20)
 DETERMINATION OF ELIGIBIL <u>X</u> 1. Facility is Eligible to P. 	TY	20. COM	IPLIANCE WITH HTS ACT:		21. 1. Statement of Fina	ancial Solvency (HCFA-257 rol Interest Disclosure Stmt	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	[: .	(L30)
OF PARTICIPATION 01/12/1967	BEGINNING	J DATE	ENDING DA	ГЕ	VOLUNTARY 0 01-Merger, Closure		<u>VTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to 1	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-FIOVID	er Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00320					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	DATE			
	(L32)	05/08/2014		(L33)	DETERMINATION APP	ROVAL	

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5097

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 03/13/14. On 05/05/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 04/24/14, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 03/13/14, effective 05/23/14. Refer to the CMS-2567B for both health and life safety code.

Effective 05/23/14, the facility is certified for 55 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5097

June 9, 2014

Ms. Shelley Solberg, Administrator Faribault Care Center 1738 Hulett Avenue North Faribault, Minnesota 55021

Dear Ms. Solberg:

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 May 23, 2014, the above facility is certified for:

55 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Are Klegese

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

May 21, 2014

Ms. Shelley Solberg, Administrator Faribault Care Center 1738 Hulett Avenue North Faribault, Minnesota 55021

RE: Project Number S5097024

Dear Ms. Solberg:

On April 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 24, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On May 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 24, 2014 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 February 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2014 and therefore remedies outlined in our letter to you dated April 8, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245097	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/5/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
FA	RIBAULT CARE CENTER		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021	I

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5) Date	(Y4)	Item		(Y5)	Date
		С	orrection				Correction					Correction
ID Drafin	50404			ID Drofin	F 04	74	Completed		ID Drofin	50005		Completed
ID Prefix	F0164		4/22/2014	ID Prefix			04/22/2014		ID Prefix	-		04/22/2014
Reg. # LSC	483.10(e), 483.75(l)	(4)		Reg. # LSC	483.	10(k),(l)	_		Reg. # LSC	483.13(c)(1)	ii)-(iii), (c	c)(2) -
							-		100			
		С	orrection				Correction					Correction
			completed				Completed					Completed
ID Prefix	F0226	0	4/22/2014	ID Prefix	F02	244	04/22/2014		ID Prefix	F0246		04/22/2014
	483.13(c)				483.	15(c)(6)	_			483.15(e)(1)		
LSC				LSC			-		LSC			
		0					O a ma ati a a					Ormertien
			orrection				Correction Completed					Correction Completed
ID Prefix	F0272		4/22/2014	ID Prefix	F02	279	04/22/2014		ID Prefix	F0282		04/22/2014
Reg. #	483.20(b)(1)			Reg. #	483.2	20(d), 483.20(k)(1)			Reg. #	483.20(k)(3)(ii)	
LSC				LSC			-		LSC			
			orrection				Correction					Correction
ID Prefix	F0285		ompleted 4/22/2014	ID Prefix	F03	809	Completed 04/22/2014		ID Prefix	F0312		Completed 04/22/2014
Reg. #	483.20(m), 483.20(e	e)		Reg. #	483.2	25			Reg. #	483.25(a)(3)		
LSC				LSC			-		LSC			
		-	orrection				Correction					Correction
ID Prefix	F0315		ompleted 4/22/2014	ID Prefix	F03	323	Completed 04/22/2014		ID Prefix	F0329		Completed 04/22/2014
Rea.#	483.25(d)			Reg. #	483.2	25(h)	_			483.25(I)		
LSC				LSC			_		LSC			
Reviewed I	By Revie	wed F	}v	Date:		Signature of Su	rvevor:				Date:	
State Agen	SD//		- ,	05/21/20	14	Signature of Su	iveyor.		16	5022		5/2014
Reviewed I	-	wed E	βγ	Date:		Signature of Su	rvevor:				Date:	
CMS RO	-		-			<u> </u>						
				1							1	

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 245097	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/5/2014
Name of Facility		Street Address, City, State, Zip Code	
FARIBAULT CARE CENTER		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021	I

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

(Y4) Item		(Y5) Date	e (Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date
ID Prefix	F0367	Correct Comple 04/22/2	ted	ix F0371	Correction Completed 04/22/2014	ID Prefix	F0406		Correction Completed 04/22/2014
Reg. # LSC	483.35(e)		Reg. LS	# <mark>483.35(i)</mark> C		Reg. # LSC	483.45(a)		_
ID Prefix Reg. # LSC	483.65	Correct Comple 04/22/2	oted ID Pref	ix <u>F0465</u> # <mark>483.70(h)</mark> C	Correction Completed 04/22/2014				
Reviewed	CD	ewed By /AK	Date: 05/21/2		e of Surveyor:	160	22	Date:	5/2014
State Agen Reviewed I CMS RO	. ,	ewed By	Date:		e of Surveyor:	100	<i>44</i>	Date:	2017
	to Survey Complete 3/13/2014				y Uncorrected Defi ed Deficiencies (CM				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 245097	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 4/24/2014
Name of Facility		Street Address, City, State, Zip Code	
FARIBAULT CARE CENTER		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021	I

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix	Correcti Comple 04/22/20	ted	Correctic Complet 04/22/20	ed		Correction Completed
0	NFPA 101	Ũ	NFPA 101	Reg. #		
LSC	K0050		K0154			
	Correcti	on	Correctio	n		Correction
ID Prefix	Comple	ted ID Prefix	Complet	ed ID Prefix		Completed
Reg. #		Reg. #		Dag. #		
		LSC		LSC		
	Correcti		Correctio			Correction
ID Prefix	Comple	ID Prefix	Complet			Completed
Reg. #		Reg. #		Reg. #		
LSC		LSC		LSC		
	Correcti Comple		Correctio			Correction Completed
ID Prefix		ID Prefix		ID Prefix		
Reg. # LSC		Reg. # LSC		Reg. # LSC		
ID Prefix	Correcti Comple	ted	Correctic Complet	ed		Correction Completed
Reg. #		Reg. #		Reg. #		
Reviewed E	By Reviewed By	Date:	Signature of Surveyor		Data	
State Agen		05/21/202	Signature of Surveyor:	12	424 Date 424	/24/2014
	By Reviewed By	Date:	Signature of Surveyor:		Date	:
Followup t	o Survey Completed on: 3/13/2014		Check for any Uncorrected D Uncorrected Deficiencies	eficiencies. Was a CMS-2567) Sent to	Summary of the Facility? YES	S NO

DEPARTMENT OF HEALTH	AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 477C
	PART I	- TO BE COMP	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00989
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245097 2.STATE VENDOR OR MEDICAID NO. (L2) 332668000		 NAME AND ADDRESS OF FACILITY (L3) FARIBAULT CARE CENTER (L4) 1738 HULETT AVENUE NORTH (L5) FARIBAULT, MN 			(L6) 55021	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 01/01/2011 6. DATE OF SURVEY 03/13/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other		 PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 	PPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	RY 09 ESRD 10 NF 11 ICF/III 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF 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 13.Total Certified Beds 	55 (L18) 55 (L17)	Complian 1 X B. Not in Con		ram	And/Or Approved Waivers Of T2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNI5. Life Safety Code * Code: B *	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN	I				15. FACILITY MEETS	
18 SNF 18/19 SNF 55	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Candace Bolduc, HFE	NE II		04/22/2014	(L19)	<u>Shellae Dietrich, Ce</u>	rtification Specialist 04/29/2014
PA	RT II - TO BI	E COMPLETED	BY HCFA R	EGIONA	L OFFICE OR SINGLE ST	CATE AGENCY
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible 	icipate (L21)		APLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	4. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 01/12/1967	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	B. Rescind Sus		(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00320				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPR	ROVAL

DEPARTMENT OF HEALTH AND	HUMAN SERVICES	CENTERS FOR MEDICA	RE & MEDICAID SERVICES
	MEDICARE/MEDICAID CERTIFICATION ANI	D TRANSMITTAL	ID: 477C
	PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00989
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS		

C&T REMARKS - CMS 1539 FORM

CCN: 24-5097

At the time of the standard survey completed March 13, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. In addition, at the time of the survey MDH completed an investigation of complaint number H5097061 that was found to be unsubstantiated. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7012 3050 0001 9094 7475

April 8, 2014

Ms. Shelley Solberg, Administrator Faribault Care Center 1738 Hulett Avenue North Faribault, Minnesota 55021

RE: Project Number S5097024 and Complaint Number H5097061

Dear Ms. Solberg:

On March 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5097061. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 13, 2014 standard survey the Minnesota Department of the March 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5097061 is enclosed. In addition, at the time of the March 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5097061 is enclosed. In addition, at the time of the March 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5097061 that was found to be unsubstantiated.

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

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

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

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

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

<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.

Faribault Care Center April 8, 2014 Page 2

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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793 Fax: (651) 201-3790

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 April 22, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Faribault Care Center April 8, 2014 Page 4 **Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by May 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 24, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Faribault Care Center April 8, 2014 Page 5

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

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Ame Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			APR 1 8 2014 APR 1 8 2014 PRINTED: 03/3 FORM APPR OMB NO. 0938	OVED
ATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION (X3) DATE SURV COMPLETE	
		245097	B. WIN	G	PLIANCE MONITORING DIVISION C ICENSE AND CERTIFICATION 03/13/20	14
AME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODÉ	
ARIBAU	LT CARE CENTER			F	ARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		D EFIX AG		X5) PLETION ATE
F.000	INITIAL COMMEN	ſS	F	- 000	This plan of correction is submitted as required under Federal and	
<u> </u>	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.		114	State laws.—The submission of this Plan of Correction does not constitute an admission on the part of Faribault Care Center as to the accuracy of the surveyors' findings	
	revisit of your facili	acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with	4120	ÉL	that the scope and severity	4 (194) 10° V(19 4-039 40 V 5
14. 	complaint investiga the time of the star An investigation of completed. The co	complaint H5097061 was mplaint was not substantiated.		F 164	the Facility's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the	
F 164 SS=D	The resident has t	I)(4) PERSONAL DENTIALITY OF RECORDS ne right to personal privacy and s or her personal and clinical		1 10-	Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on this basis. The Facility submits this plan of correction with the	.
•	medical treatment communications, p meetings of family	ncludes accommodations, written and telephone personal care, visits, and and resident groups, but this ne facility to provide a private dent.			intention that it be inadmissible by any third party against the Facility or any employee, agent, officer, director, attorney, or shareholder of the Facility or affiliated companies.	
• •	section, the reside	d in paragraph (e)(3) of this nt may approve or refuse the al and clinical records to any the facility.		1		
BORATÓR	Y DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	ANATUR	A	ministration 04/12	ATE.

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

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		AND HUMAN SERVICES			PRINTED: 03/31/201 FORM APPROVEI	D
CENTERS FOR STATEMENT OF DEFIC AND PLAN OF CORREC	ENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	<u>)</u>
		245097	B. WING		C 03/13/2014	
NAME OF PROVIDER	OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1738 HULETT AVENUE NORTH		
FARIBAULT CARI	CENTER			FARIBAULT, MN 55021		
PREFIX (EAG	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION	N
The res	ical records	t to refuse release of personal does not apply when the	F 1	64 F164		
institution The fact contain the form release	on; or record ility must ke ed in the res or storage is required	red to another health care d release is required by law. eep confidential all information sident's records, regardless of e methods, except when by transfer to another on; law; third party payment		 R46 has been discharge the facility. Confidential period information that was poste public area of facility was removed.R25 is deceased. All staff have been eduction 	ersonal d in a ated	× 4.2
, , , , , , , , , , , , , , , , , , ,	t; or the res QUIREME	ident. NT is not met as evidenced		regarding appropriate prov privacy. Smoking schedule remain as it is for any resio smokes-resident informatio not be placed on the smok	e will lent who on will	-
review privacy observe confide	he facility fa during care d for incon ntially post	tion, interview and document ailed to ensure personal es for 1 of 3 residents (R25) tinence and the facility failed to personal information for 1 of 4 served smoking.		schedule. Education comp 3/25/2014 3. Director of Nursing/Desig will provide education to all related to the posting of pe information and policy and	oleted gnee staff	• • • • •
R25 lac During stated s provide R25 wa provide	an interview staff did not privacy du s observed d by nursing	during incontinence cares g assistant (NA)-J and trained		procedure for providing priv during cares and promoting resident dignity. 4. 3 residents will be monito weekly x 4 wks then 1 resid week for 3 months for priva infringements. Monitoring y completed by SDC, Admini and DON and or designee.	ored lent per lcy will be strator	
medica 1:30 p. was ob TMA-E the roo providin	tion aide (T n. and 1:50 served to u was observ m without p ng personal	MA)-E on 3/12/14 between p.m. During the cares R25 rinate on the bed linens. ved to open the door and leave ulling the privacy curtain or privacy to R25 who was lying MA-E reentered the room		 5. Any concerns identified waddressed at the facility's CAssurance meeting 6. The facility will be in subscompliance by 04/22/2014 	Quality	

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DEFENSION (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	
245097 B. WING O3/13/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (() F 164 Continued From page 2 F 164 F 164	EY
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FARIBAULT CARE CENTER (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) (a) COMP DF COMP DF F 164 Continued From page 2 F 164	
(A4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DA F 164 Continued From page 2 F 164 F 164 F 164	
	5) LETION ITE
personal privacy was provided to R25.	
TMA-E was interviewed at 1:50 p.m. and stated the privacy curtain should have been pulled before she exited the room.	
During an interview on 3/13/14 at 11:45 a.m. the director of nursing stated privacy was an expectation of care.	
R46 lacked confidentiality of personal smoking information.	
On 3/10/14 at 5:30 p.m. a sign was observed posted in the nursing area/dining room/resident activity area that stated [R46's name in bold typing] Smoking Schedule. The sign listed the times and mount of cigarettes R46 could smoke	
During an interview on 3/10/14 at 5:11 p.m. R46 stated the cigarettes were locked up and felt rights were taken away.	
R46 was observed on 3/12/14 at 7:10 p.m., on 3/13/14 at 7:35 a.m. outside to smoke under staff supervision. Each time R46 was observed to ask staff to be able to smoke.	
Review of documents identified the facility completed a smoking assessment on 2/6/14 that stated the resident required supervision, had cognitive loss, and had been observed smoking	
in bedroom or bathroom. The facility elopement risk assessment dated 2/6/14 noted under smoking, "will jump fence if given a chance". No assessment/ analysis of data was provided. If continuation sheet Page FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:477C11 Facility ID: 00989 If continuation sheet Page	

		AND HUMAN SERVICES		PRINTED: FORM A OMB NO. (PPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION (X3) DATE COMP	SURVEY
		245097	B. WING	C 03/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	<u>I</u>		STREET ADDRESS, CITY, STATE, ZIP CODE	
FARIBA	ULT CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(X5) COMPLETION DATE
F 164	Continued From pa	ige 3	F1	164	
F 174 SS=D	focus related to sm directed the resider while smoking, that be locked up. During an interview director of nursing (R46 had smoking is schedule had been had wanted to go o and needed superv risk. DON stated th schedule in a public 483.10(k),(I) RIGHT WITH PRIVACY §483.10(k) Telepho The resident has th access to the use o be made without be §483.10(I) Persona The resident has th personal possessio furnishings, and ap permits, unless to o rights or health and This REQUIREMEN by: Based on observat review the facility fa	e right to have reasonable of a telephone where calls can being overheard. I Property e right to retain and use ons, including some propriate clothing, as space to so would infringe upon the safety of other residents. NT is not met as evidenced tion, interview and document uiled to ensure privacy during r 1 of 1 (R46) residents	F 1	 F174 R46 has been discharged from the facility, Staff will move residents to private location when they are requiring a private phone conversation. Social Service Designee/designee will complete an audit with each resident to ensure they have a private place to talk on the telephone. Social Service Designee/designee will educate all staff 04/17/2014 on providing a private place for residents to have a private place for residents to have a private place for resident sto have a private place for resident to telephone conversation. Social Service Designee/designee will monitor telephone privacy through resident council monthly. Any concerns identified will be addressed at the facility's Quality Assurance meeting. The facility will be in substantial compliance by 04/22/2014 	4/22/14

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

Facility ID: 00989

If continuation sheet Page 4 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	Сом	E SURVEY PLETED
		245097	B. WING			C 03/13/2014	
	PROVIDER OR SUPPLIER			1738 H	T ADDRESS, CITY, STATE, ZIP CODE IULETT AVENUE NORTH BAULT, MN 55021	r	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 174	Continued From pa		F1	74			
	_R46_was_not_provid	ed privacy during phone calls.					
	stated not allowed	on 3/10/14 at 5:11 p.m. R46 to use the portable telephone taken away. "Make me sit ".					
	sitting in the hallwa nursing station. Th were within hearing 10:19 a.m. R46 stat be private because provider. R46 state that the use of the 3/12/14 between 1: observed to use the	on 3/12/14 at 10:05 a.m. y using the telephone in the ree staff and three residents distance. On 3/12/14 at ted the telephone call was to it was to a health care ed did have a cell phone, but cell phone cost money. On 00 p.m. and 3:00 p.m. R3 was e telephone at the nursing When asked, resident stated vere not private.					
1. 1. 1. 1.	admitted to the me The admission Min 11/5/13 indicated th interview of mental no cognitive impair	nts indicated R46 was mory care unit on 11/5/13. imum Data Set (MDS) dated he resident had a brief status score (BIMS) of 13 or ment, displayed no behaviors, ent with all activities of daily					
	The sign stated, " F	outside the memory care unit. Resident phone is not allowed ntil further notice. Thank you."					
	director of nursing was available in the stated it was her ur	on 3/13/14 at 12:10 p.m., the verified no portable telephone e memory care unit. DON inderstanding that R46 would for hours and not allow other GObsolete Event ID:477C1		Facility II			Page 5 of 82

PRINTED: 03/31/2014

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		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 03/31/2014 FORM APPROVED MB NO. 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		245097	B. WING		C 03/13/2014
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FARIBAU	JLT CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021	
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 174	residents to use the incident of being at	phone. DON verified the the nursing station with staff	F 174		
		cy issue, but added the			
F 225 SS=E	designee (SSD) on verified the portable the memory care un that the nursing stat use. SSD stated R- R46 to have access her. SSD stated the was not private. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF	ORT	F 225		
	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have abusing, neglecting, or s by a court of law; or have d into the State nurse aide abuse, neglect, mistreatment ppropriation of their property; vledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry			
	involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and ccordance with State law procedures (including to the ctilication agapav)			

Facility ID: 00989

If continuation sheet Page 6 of 82

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/31/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CO	(X3) DAT CON	E SURVEY IPLETED	
		245097	B. WING				C /13/2014
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		and the second
FARIBAL	JLT CARE CENTER				HULETT AVENUE NORTH BAULT, MN 55021		
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F 225	Continued From pa	-	F 2	225 F	F225 1. Social Service Design spoke with Residents		
	violations are thorou prevent further pote investigation is in pr The results of all inv to the administrator representative and	vestigations must be reported or his designated to other officials in accordance			 12, 16, 59 63, and 70 identify if the grievand have been resolved. All Unusual Occurrer in the last 30 days we reviewed by DON/Adu 	to ces nces ere min	
1, 10, 11 1, 10, 11 1, 10, 11	certification agency incident, and if the a	iding to the State survey and) within 5 working days of the alleged violation is verified ve action must be taken.			to identify if any other injuries of unknown of should be reported to State Agency. 3. Policy and Procedure reporting was reviewe	rigin the for	
	by: Based on observat review the facility fa of potential abuse w and immediately rej 6 of 8 residents (R1 the sample who rep addition, the facility	NT is not met as evidenced ion, interview and document iled to ensure all allegations vere thoroughly investigated ported to the state agency for 2, R1, R70, R16, R59, R63) in orted allegations of abuse. In failed to ensure these ected from potential retaliation on was pending.			 DON with all staff on 03/25/2014 to ensure occurrences are report and investigated timel administrator/ designed All Unusual Occurrence will be reviewed week Interdisciplinary Team/designee to ensure proper communication investigation, and 	all ted y by ee. ces ly by ure	
	R12, R1, R70, R16, allegation of potenti to thoroughly invest the resident from po investigation was pe	R59, R63 reported an al abuse and the facility failed igate the allegation, protect otential abuse while an ending and immediately report			reporting has occurred weekly or until a lesse time is deemed appropriate. 5. Any concerns identified will be addressed at th	r	
FORM CMS-25		I observation and interview on ., R12 stated, "I think they		Facility I	facility's Quality Assura meeting. 6. The facility will be in substantial compliance	ance	4/22/14 t Page 7 of 82

STATE MENU OF DEPIDEROISE AND PLAND FOR CORRECTION (P1) PMOVEBBUEFULA DESTINATION NUMBER C2 MULTIPLE CONSTRUCTION A BUILDING (P3) DATE SURVEY C C 03/13/2014 INME OF IMMOVIDER OR SUPPLIER 245097 Is WING C1 03/13/2014 FARIBAULT CARE CENTER STITEET ADDRESS, GITY, STATE, 2P 000E T738 HULET AVENUE NORTH C1 03/13/2014 PARIBAULT CARE CENTER STITEET ADDRESS, GITY, STATE, 2P 000E T738 HULET AVENUE NORTH C1 03/13/2014 PARIBAULT CARE CENTER STITEET ADDRESS, GITY, STATE, 2P 000E T738 HULET AVENUE NORTH C2 0000ERS PLANOT CONNECTION PROVIDER OR ADDRESS D0 C1 00053HE2FERE/CTV ADTION SHOULD DE CROSSHE2FERE/CTV AD			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
245097 B. WING 03/13/2014 NAME OF PROVIDER ON SUPPLER STREET ADDRESS, GTV, STATE, ZP CODE 1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER ITEM HULETT AVENUE NORTH FREETA DORESS, GTV, STATE, ZP CODE Image: Construction of the Construction of DEFICIENCIES Image: Construction of the Construction o	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /			(X3) DATE COM	E SURVEY PLETED
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FARIBAULT CARE CENTER FARIBAULT, MN 55021 IM) D PHEERX TAG SUMMARY STATEMENT OF DEFICIENCIES INCAMENT STATEMENT OF DEFICIENCIES INCAMENT STATEMENT OF DEFICIENCIES PHEERX TAG PROVIDER'S FLAN OF CORRECTION (EACH CONRECTINE ACTION SHOLD BE CROSS-REFERENCE AT ACTION SHOLD AT ACTION THE STATE AT ACTION SHOLD BE CROSS-REFERENCE AT ACTION THE STATE AT A REVERSION AT TAG F 225 Continued From page 7 need better training in respect and light on and it was taking avhile so as stood by the dood way and two stat walked bo and the problems but they don't follow through now I Be extra at at a the action the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through and R12 stated facial expression. R12'S Briel Interview for Montal Status (BIMS) dated 12/11/13 indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitive intact. </th <th>NAME OF I</th> <th>PROVIDER OR SUPPLIER</th> <th></th> <th></th> <th></th> <th></th> <th>DE</th> <th></th>	NAME OF I	PROVIDER OR SUPPLIER					DE	
Mathematic read-fibric/rescription of Production PREFX read-clock contention condition F 225 Continued From page 7 need better training in respect and dignity which 1 consider to be abusive here: "When asked to further explain R12 stated, "I have heard the staff yell at the lady neutowork door and have complained myself about how 1 was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude. "R12 tatked about another situation when she had the call light on and it was taking comments like, "Yah, what do you want? You should be able to do it your oxygen hose because 1 know how to do it." R12 referred to the staff making comments like, "Yah, what do you want? You should be able to do it yourosellt" R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 stated not being conflictent staff are passing on the information. R12 was beserved to have a frustrated facial expression. R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact. A review of the resident council minutes from December 2013 under the section "Oid Business" read "Don't appreciate the evening CNA's (certified nursing assistant) commis in saigning they are to tuby to help" This concern was addressed by R12. Upon review of the form tited "Resident/Family Crievance/Concern Form" for	FARIBAU	JLT CARE CENTER						
need better training in respect and dignity which I consider to be abusive here. "When asked to further explain R12 stated," Thave heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude." F12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as F12 was trying to get their attention one of them said "Not now! Better be careful, 1 will cut off your oxygen hose because I know how to do it." F12 referred to the staff making comments like, "Yah, what do you want? You should be able to do it yourself!" F12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. F12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and F12 stated not being confident staff are passing on the information. F12 was obser	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x ci	(EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
further explain R12 stated, "I have heard the staff yell at the lady next door and I have complained myself about how I was treated, but they don't believe me here. Look at the resident council minutes, we keep telling them about the problems but they don't follow through, the staff are verbally abusive and rude." R12 talked about another situation when she had the call light on and it was taking awhile so she stood by the doorway and two staff walked by as R12 was trying to get their attention one of them said "Not now! Better be careful, I will cut off your oxygen hose because I know how to do it." R12 referred to the staff making comments like, "Yah, what do you want? You should be able to do it yourseft!" R12 referred to the staff as getting defensive with her but she cannot see the names on the name tags. R12 said she had reported situations to the resident council, and there should be criteria in place so you know who you have talked to and so people will follow through. They don't follow through and R12 stated not being confident staff are passing on the information. R12 was observed to have a frustrated facial expression. R12's Brief Interview for Mental Status (BIMS) dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterms indicating cognitively intact. A review of the resident council minutes from December 2013 under the section "Old Business" read "Don't appreciate the evening CNA's (certified nursing assistant) coming in saying they are tot busy to help" This concern was addressed by R12. Upon review of the form titled "Resident/Family Grievance/Concern Form" for	F 225	need better training	in respect and dignity which I	F 2	225			
dated 12/11/13, indicated a summary score of 13 out of a possible 15 for cognitive patterns indicating cognitively intact.A review of the resident council minutes from December 2013 under the section "Old Business" read "Don't appreciate the evening CNA's(certified nursing assistant) coming in saying they are tot busy to help" This concern was addressed by R12. Upon review of the form titled "Resident/Family Grievance/Concern Form" for		further explain R12 yell at the lady next myself about how I believe me here. Lo minutes, we keep to but they don't follow abusive and rude." situation when she taking awhile so she two staff walked by attention one of the careful, I will cut off know how to do it." making comments You should be able to the staff as gettir cannot see the nam said she had report council, and there s you know who you will follow through. R12 stated not bein on the information. frustrated facial exp	stated, "I have heard the staff door and I have complained was treated, but they don't ook at the resident council elling them about the problems / through, the staff are verbally R12 talked about another had the call light on and it was e stood by the doorway and as R12 was trying to get their m said "Not now! Better be your oxygen hose because I R12 referred to the staff like, "Yah, what do you want? to do it yourself!" R12 referred ng defensive with her but she nes on the name tags. R12 ed situations to the resident should be criteria in place so have talked to and so people They don't follow through and ng confident staff are passing R12 was observed to have a pression.					
by R12. Upon review of the form titled "Resident/Family Grievance/Concern Form" for		dated 12/11/13, ind out of a possible 15 indicating cognitive A review of the resi December 2013 un read "Don't appreci (certified nursing as	icated a summary score of 13 of for cognitive patterns ly intact. dent council minutes from der the section "Old Business" ate the evening CNA's ssistant) coming in saying they					
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 477C11 Facility ID: 00989 If continuation sheet Page 8 of 82		by R12. Upon revie "Resident/Family G	w of the form titled rievance/Concern Form" for			0000 "		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245097	B. WING	i		C 03/13/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		·
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP! DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225		ge 8 ad, "During resident council ou being treated with dignity	F	225			
н. 1. с.	and respect, she re was told, I have 30 any grief." R12 did it was in the evenin to Administrator 11/	sponded Not always and said patients today, don't give me not know who it was, only that g and it was a CNA. Reported 7/13. The administrator wrote e interviewed two nursing				•	
	The facility was una	estigation or staff education					
	R1's BIMS dated 2/ score of 5 out of a p patterns indicating s	20/13, indicated a summary possible 15 for cognitive severe impairment.					
	minutes, the quest you are treated with was quotes, "Some you." During an initi on 3/11/14, at 2:09 here abused you R stated, "Verbal abus yelled at for needing at the resident cour disposition for her of continues to have of "Sometimes they ge me for calling out for					•	
		estigation or staff education vance expressed from the					

Facility ID: 00989

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		(X3) DATE COMF	PLETED	
		245097	B. WING			03/13/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, 1738 HULETT AVE	CITY, STATE, ZIP CODE			
FARIBAU	ILT CARE CENTER			FARIBAULT, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CO	DER'S PLAN OF CORREC PRECTIVE ACTION SHC ERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 225	Continued From pa	ge 9	, F 2	25				
	3/11/14 ,at 1:29 p.m R70 stated, "I have residents and will si you want." R70 said informed and he ha that people get yells further expressed a scolded and reprim and then he feels th R70 mentioned the him have been verts stated, "people are to ask to go to the b yelled at, I have hea observed to have a responding to the q R70's BIMS dated 2 score of 14 out of a patterns indicating of	2/18/14, indicated a summary possible 15 for cognitive cognitively intact.						
	or concern documa education regarding R59's documents w	vere reviewed and upon			¢			
	"Resident asked for Stated 'everyone al feel like a drug reha out the cards and le	dated 2/18/14, by R59 read, r his pills staff went off on him. ways wants these pain pills. I ab. Then said I should just get et them just take them.'						
	this it would hurt. S problems." The Res	is stomach and said if you had he stated I've had worse sponse /Internal investigation iber read, "Reviewed		5				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	СОМ	E SURVEY PLETED
· .		245097	B. WING				13/2014
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	ILT CARE CENTER				NBAULT, MN 55021		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	education regarding	involved and did staff	Fź	225			
	verified the staff me	sident infraction." on 3/13/14, at 1:15 p.m., R59 ember was disrespectful and e anymore conversation about					1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.
ан 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	score of 15 out of a patterns indicating of The facility was una	able to produce any estigation or staff education				·	8. <u>0291</u> 8. <u>0291</u> 8.
	council meeting No week in the evening lady came into his r Resident could not happened. The inter read, the writer call to residents legs be moved his legs, but was wet, aide chan knees to roll him ov						
۱ 	score of 12 out of a patterns indicating The facility was una documentation, invo	estigation or staff education					
	regarding R16's gri	evance.					

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Facility ID: 00989

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED C
		245097	B. WING	ì			13/2014
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	R63 had a grievand	ge 11 e concern which read, "Had a], She was rude and abusive	F 2	22	5		
· · · · ·	to me, she said, 'I s everyday,' It was he thought the inciden requested care and The response to the	houldn't have to do this er tone, terrible attitude." R63 t was at night on Sunday. R63 I the staff member did nothing. e grievance read, "Talked to remember being this way,					
	score of 15 out of a patterns indicating						
	The facility was una documentation, inv regarding R63's gri	estigation or staff education					
	"Abuse Prevention read, "Interview the witnesses. Witness (1) witnessed or he close contact with t incident {including of members}; and (3) closely with the acc alleged victim the d written statements the accused, and e policy defines verba written or gestured disparaging and de	ity policy dated 3/5/13, titled Plan" under step 6. Investigate resident, the accused, and all es shall include anyone who: ard the incident; (2) came in he resident the day of the other residents, family employees who worked used employee (s) and/or ay of the incident. Obtain from the resident, if possible, ach witness." The facility al abuse as, "The use of oral, language that willfully includes rogatory terms to residents."					
	administrator was u documentation from the protection, inve	on 3/13/14, at 1:30 p.m. the inable to produce any n any other source regarding stigation, education or training					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: 477C1	1	, F	Facility ID: 00989 If contin	uation sheet	Page 12 of 82

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PRINTED: 03/31/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245097	B. WING	i		C 03/13/2014	
NAME OF F	PROVIDER OR SUPPLIER	an a			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER				738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	on abuse related to R12, R1, R70, R59,	the specific grievances for R16 or R63 and stated, "I	F2	225			
F 226 SS=E	don't know why they abuse." The admini were dealt with but documentation to cr complaints. The administration resident complaints should have been ro The administrator v have been protecter verbal abuse and th not implemented for 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle	weren't reported as verbal strator thought the grievances could not produce any bincide with the resident ministrator validated the were verbal abuse and eported to the State Agency. alidated the residents should d pending investigation of the e abuse prevention plan was r these residents. P/IMPLMENT ETC POLICIES velop and implement written	F 2	226			
	by: Based on interview facility failed to impl and procedures to p allegations of poten investigate allegatio report allegations of facility's administrat 8 residents (R1, R1, sample who reporte	IT is not met as evidenced and document review the ement established policies protect residents who reported tial abuse, thoroughly ns of abuse and immediately potential abuse to the or and state agencies for 6 of 2, R16, R59, R63, R70) in the d allegations of abuse.					
	Findings include: R1, R12, R16, R59,	R63 and R70 reported an					· · · · · · · · · · · · · · · · · · ·

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	1	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	: 03/31/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRU	JCTION	(X3) DAT COM	E SURVEY
		245097	B. WING					C
NAME OF F	PROVIDER OR SUPPLIER		L	ST	TREET ADD	RESS, CITY, STATE, ZIP CODE	1 00/	10/2014
FARIBAU	JLT CARE CENTER			1 ·		T AVENUE NORTH T, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EA	PROVIDER'S PLAN OF CORRECTIC CH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	allegation of potent	ige 13 ial abuse and the facility failed tigate the allegation, protect	F:	226	F226	 Social Service Design spoke with Residents 	1ee #1	
	the resident from po- investigation was po- the allegation to the A review of the facil	otential abuse while an ending and immediately report		-		12, 16, 59 63, and 70 identify if the grievanc have been resolved. Abuse prevention plar be followed and all	to es	
	read, "Interview the witnesses. Witness (1) witnessed or he close contact with the incident {including of members}; and (3)	resident, the accused, and all es shall include anyone who: ard the incident; (2) came in he resident the day of the other residents, family employees who worked			2.	accusation of abuse w reported to the state agency. Audit completed of all staffs knowledge of	ill be	
	alleged victim the d written statements if the accused, and ex policy defines verba written or gestured	used employee (s) and/or ay of the incident. Obtain from the resident, if possible, ach witness." The facility al abuse as, "The use of oral, language that willfully includes rogatory terms to residents."			3.	Unusual Occurrence/Abuse Neg Policy and Procedure b administrator/designee All staff educated on 3/25/14 Unusual Occurrence/ Abuse	οv	
Karixi	the administrator, si further documentation regarding the protect or training on abuse grievance for R1, R	on 3/13/14, at 1:30 p.m. with he was unable to produce any ion from any other source ction, investigation, education e related to the specific 12, R16, R59, R63 or R70 know why they weren't			4.	Neglect reporting and investigating by administrator/designee. Administrator/designee complete random staff audits to ensure	will	
	reported as verbal a thought the grievan produce any docum resident complaints the resident compla	abuse." The administrator ces were dealt with but cannot nentation to coincide with the The administrator validated ints were verbal abuse and eported to the State Agency.			5.	knowledge of Unusual Occurrence/Abuse Negl Policy and Procedure. Any concerns identified will be addressed at the		
FORM CMS-25	The administrator v have been protected	alidated the residents should d pending investigation of the ne abuse prevention plan was r those residents.		Facil	6. lity I	facility's Quality Assurar meeting. The facility will be in substantial compliance b 04/22/2014	у	4/22/14 Page 14 of 82

		AND HUMAN SERVICES			FC	TED: 03/31/20 DRM APPROV NO: 0938-03	ΈD
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		245097	B. WING			C 03/13/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		4
FADIDAL				1	738 HULETT AVENUE NORTH	s stra	1
FARIBAL	JLT CARE CENTER			F	ARIBAULT, MN 55021	1.1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE	ON
						÷	
F 244 SS=E	483.15(c)(6) LISTE GRIEVANCE/REC	N/ACT ON GROUP	Fź	244			
50=E					F244		
	When a resident or	family group exists, the facility			1.Resident(s) #2, 12, 28, 31, 53,	· · · · · · · · · · · · · · · · · · ·	
	must listen to the v	iews and act upon the			and #58 concerns were addressed		
		ommendations of residents rning proposed policy and			and follow up was completed.		
	operational decisio	ns affecting resident care and			2. Social Service		4
	life in the facility.				Designee/designee will complete		
	•				an audit of complaints/grievances		:
		NT is not mat as suideneed			made during resident council for)
	by:	NT is not met as evidenced			the last 30 days.		
	Based on interviev	v and document review, the			3. Administrator/designee		
	facility failed to act	upon resident grievances			educated Social Service Designee		
		g of the call lights for 6 of the			04/17/2014 on policy and	11 11 11 11 11 11 11 11 11 11 11 11 11	
	43 residents (R12,	, R2, R31, R53, R58, R28) who			procedure for completing		· · · · · ·
	call lights being an	ty who expressed concern with			complaints/grievances.		
-		Swered.			4. Administrator /designee will		• • •
	Findings include:				review resident council meeting		
					notes to ensure all		
	R12 stated, during	an initial interview on 3/10/14,			complaints/grievances have been	•	·· · · ·
a al 3 -	at 5:00 p.m., "I thin	k they need better training in which I consider to be abusive			filed and followed through on		يۇنىچە
	here." When asked	to further explain R12 stated,			weekly with weekly grievance		
	"I have heard the s	taff yell at the lady next door			review.		
		ned myself about how I was			5. Any concerns identified will be		
		on't believe me here. Look at			addressed through the Quality		
		I minutes, we keep telling them s but they don't follow through,			Assurance meetings		
S		ly abusive and rude." R12			6. The facility will be in substantial	4/2/1	1
		er situation when she had the			compliance by 04/2202014	112211	7
		vas taking awhile so she stood					
		d two staff walked by as R12					
		eir attention one of them said e careful, I will cut off your					
		use I know how to do it." R12					
	referred to the staff	f making comments like, Yeh,					
		You should be able to do it					
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		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
	4	245097	B. WING	I			, 3/2014	
NAME OF F	PROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE, ZIP CODE			
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 244	defensive with her l	red to the staff as getting but she cannot see the names	F	244				
	situations to the res should be criteria in have talked to and They don't follow th	R12 said she had reported sident council, and there n place so you know who you so people will follow through. irough and R12 is not passing on the information.						
allar 12.05 23.15	(BIMS) dated 12/11	ief Interview for Mental Status /13, indicated a summary possible 15 for cognitive cognitively intact.						
	reviewed and docu (1) 3/6/14, several of were brought up su coming into the roo then leave and don R2 said, You have y and shut it off and s have someone else happens more than on for a half hour to R31 said, call lights the evening.	concerns regarding call lights ich as R12 expressing staff im, whip off the call light and 't come back. your call light on, they come in say they will be back, they to take care of, and this in once, I can have my call light						
	meal times and cal according to R2, R (3) 1/2/14, R31 Wh	en asked about the call light				×	n og Artenso Storage Artenso	
	answered, so few,(minutes. Meal time answer lights.	expressed, will they ever be two) people working, takes 40 s there is no one around to	1	Ec	cility ID: 00989 If continuati	on sheet	Page 16 of 82	
FURM CMS-2	567(02-99) Previous Versions	Event ID:4//01	1	ra	inty 12, 00000 II COntinuati	OU SHEEL	aye 100102	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245097 B. WING 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03/13/2014 FARIBAULT CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER SIMMABY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES			-		FORM	03/31/2014 APPROVED 0938-0391
245097 B. WING 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE FARIBAULT CARE CENTER T738 HULETT AVENUE NORTH PARIDAUT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ERE PROEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MUST ERE PROEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDENT SUM OF CORRECTION (EACH DEFICIENCY MUST ERE PROEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDENT SUM OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) CMM_HTMD F 244 Continued From page 16 R53 agreed and commented Yes, takes half an hour. F 244 F 244 R13 expressed Staff needs to slow down, they want to throw you together and get out of there, some cares require more time F 244 (4) 12/5/13, R53 commented it took half an hour to forty five mutes to answer the call light. R21 said half the time the CNA (certified nursing assistants) are not reporting my request to the TMA (trained medication aide). ID Documentation was lacking to indicate the concerns recommended its assure the grievances had been remedied. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·				(X3) DATE COMF	SURVEY PLETED
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I readent call lights The ALL passes the meeting		activity director (AE residents concerns meetings are to be form by the departr be the director of n although all staff w	 it was confirmed that expressed at resident council documented on a grievance ment involved. Call lights would ursing (DON)responsibility ere responsible to answer 						
minutes on to the department heads and they are to process a grievance form. The DON had attended the December and January resident council meetings and informed residents audits were being conducted of the resident call light response times, and that a memo was posted to		minutes on to the c to process a grieva attended the Decer council meetings a were being conduc	lepartment heads and they are nce form. The DON had mber and January resident nd informed residents audits ted of the resident call light					·	
response times, and that a memo was posted to staff. The DON did not attend the February and March resident council meetings but answered the resident concerns of the call lights not being If continuation sheet Page 17 of FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 477C11 Facility ID: 00989 If continuation sheet Page 17 of		staff. The DON did March resident cou the resident conce	not attend the February and incil meetings but answered rns of the call lights not being		,	2016 x 10x 00090	lf genetien of	tion ob a st	

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		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245097	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	Continued From pa	ne 17	F 2	44			
	answered timely by were ongoing and a	referring to the audits that memo being posted to the					
	staff regarding answ verified the resident	vering call lights. The AD ts continiued to express h the answering of the call					
		oming increasingly frustrated of the call lights has been a nonths.					
	R2 regarding reside expressed at reside	on 3/13/14, at 8:30 a.m. with ent council and concerns ent council, she stated, " I put. y shut it off mostly on the					
	evening shift. They they rush along and sick of it." R2 furthe being brought up at "It constantly contin get by with this, I ha told there is no one	are short of help all the time, I say we gotta go now, you get rexpounded on concerns resident council and stated, ues to happen, why can they ave incontinence, I have been to help me. I have pooped in					
	come. Now I have I	ns ago waiting for someone to earned to call on the phone to tell the nurses but I don't know with my complaints."					
	Mental Status (BIM summary score of 1	of R2's Brief Interview for S) dated 1/20/14, indicated a 15 out of a possible 15 for ndicating cognitively intact.					
	administrator was u documentation to v concerns expressed follow up discussed	on 3/13/14, at 1:30 p.m. the nable to produce any alidate the resident specific d were investigated and/or a to their satisfaction with the				·	
F 246	missed a step in the	nistrator stated, "We have e process." ONABLE ACCOMMODATION	F 2	46			

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

Facility ID: 00989

If continuation sheet Page 18 of 82

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED AND PLAN OF CORRECTION 245097 B. WING COMPLETED NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03/13/201 FARIBAULT CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPL COMPLETED F 246 Continued From page 18 SS=D OF NEEDS/PREFERENCES F 246 F 246 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. F 246 F 246 1.Resident #4 Hearing aid was found immediately when it was reported missing, hearing aidwas in working order. 2. Director of Nursing/designee will complete an audit of all residents with hearing aides to assure they	OVED	RINTED: 03/31/20 FORM APPROV	FO			AND HUMAN SERVICES		
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SS=D OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. F246 1.Resident #4 Hearing aid was found immediately when it was reported missing, hearing aidwas in working order. Director of Nursing/designee will complete an audit of all residents with hearing aides to assure they	LETION	BE COMPLET	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		F	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: F246 1.Resident #4 Hearing aid was found immediately when it was reported missing, hearing aidwas in working order. 2. Director of Nursing/designee will complete an audit of all residents with hearing aides to assure they				246		-		1
 review, the facility failed to ensure the use of functioning hearing aides for 1 of 2 residents (R4) observed with hearing aides. Findings include: During observation and interview on 3/10/14, at 7:00 p.m. R4 was complaining about not being able to hear despite having a hearing aide present in the left ear. R4 said she had reported the missing hearing aide to her right ear, but did not know what the facility was doing about finding or replacing the hearing aide. Nursing assistant NA-B came into the room and when questioned did not know what happened to the hearing aide or why the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to change the battery for R4 but R4 could not hear the conversation which surveyor typed out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m., 		s was was we will the	 Resident #4 Hearing aid was found immediately when it was reported missing, hearing aidwas in working order. Director of Nursing/designee w complete an audit of all residents with hearing aides to assure they are in use and battery size identified Director of Nursing/ educated staff 03/25/2014 on assisting residents with hearing aides and checking to ensure there are functional. Direct Care Staff will check hearing aide batteries daily Any concerns identified will be addressed at the facility's Quality Assurance meeting The facility will be in substantia 			lity with reasonable of individual needs and ot when the health or safety of her residents would be ENT is not met as evidenced ation, interview and document failed to ensure the use of g aides for 1 of 2 residents (R4) ring aides. In and interview on 3/10/14, at complaining about not being te having a hearing aide ear. R4 said she had reported g aide to her right ear, but did facility was doing about finding earing aide. Nursing assistant e room and when questioned happened to the hearing aide he left ear was not working. do you communicate NA-B rs and stated, "We make it her." The nursing assistant ge the battery for R4 but R4 conversation which surveyor omputer for R4 to read and	services in the facil accommodations o preferences, excep the individual or oth endangered. This REQUIREMED by: Based on observat review, the facility f functioning hearing observed with hear Findings include: During observation 7:00 p.m. R4 was of able to hear despitu present in the left ef the missing hearing not know what the or replacing the he NA-B came into the did not know what or why the one in the When asked how of shrugged shoulder work, I'm used to h attempted to chang could not hear the typed out on the co answer questions.	
During an observation on 3/13/14, at 11:50 a.m., ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 477C11 Facility ID: 00989 If continuation sheet Page 1								,

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CENTERS FOR MEDICARE & MEDICARD SERVICES OWB NO. 0938-0391 STATEWATOR OF DEPICIENCES MULTIPLE CONSTRUCTION (WS) DOWE NO. 0938-0391 AND FLAN OF CORRECTION INP PROVEMENDATION NUMBER: A BUILDING (WS) DOWE NO. 0938-0391 NAME OF PROVIDER OR SUPPLIER 245097 IS WING STREET ADDRESS OTTY STRE 20 PODE FARBAULT CARE CENTER STREET ADDRESS OTTY STRE 20 PODE 03/13/2014 PARE OF PROVIDER OR SUPPLIER STREET ADDRESS OTTY STRE 20 PODE 03/13/2014 PRETM SUMMARY STATISTING OF DEPICIENCIES PRETM PROVIDERS TRANC OCORRECTION PRETM SUMMARY STATISTING OF DEPICIENCIES PRETM PROVIDERS TRANC OCORRECTION 03/13/2014 PARE OF PROVIDER OR SUPPLY ADDRESS OTTY STREE, 20 PODE TYRE ADDRESS OTTY STREE, 20 PODE TYRE ADDRESS OTTY STREE, 20 PODE 03/13/2014 F 246 SUMMARY STATISTING OF DEPICIENCIES PRETM PROVEMENT REAL OF CORRECTION DOME NO. 00000000000000000000000000000000000			AND HUMAN SERVICES			FOR	D: 03/31/2014 MAPPROVED
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTT, STATE, PRODUCE FARIBAULT CARE CENTER SUMMARY STATEMENT OF DEFICIENCES. IF CALL DEFICIENCY WART BE PRECEDED BY FULL REQULATORY OR USD DENTFYING INFORMATION PROVIDERS RLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS HEPERECTIVE ACTION SHOLD BE CROSS HEPERECTIVE ACTION SHOLD BE CROSS HEPERECTIVE ACTION SHOLD BE CROSS HEPERECTIVE ACTION SHOLD BE DEFICIENCY 0.05 (EACH CORPORTING ACTION OF USD DENTFYING INFORMATION) F 246 Continued From page 19 R4 was on her way to the beauty shop and did not have her hearing aldes in the mesocial service F 246 designee (SSD) was questioned about the hearing aldes and did not have a missing item or concern form and was not aware the right hearing alde was missing. About D. m. R4 was interviewed and stated. This is not the new one, (pointing to right early be the medication cart and put them in R4's ears and she can hear now, they are working just fraw. Al 30.0 m. R4 was interviewed and stated. This is not the new one, (pointing to right early be the my old hearing aldes that domt work." R4 was not able to hear surveyor. Interview with RNA Averified the fid not know the hearing aide as tweek. R4's active diagnosis from the minimum Data Set (MDS) form dated 12/20/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, '1 am at risk for social isolation because 1 am hard of hearing. Make certain I am avening my hearing aides prior to the start of an activity. Furthermore, the plan of care revised 71/013, read, 'I have extensive hearing loss. Potential for impairment.''. The interventions read, 'I want my hearing aids leit in my			245097	B. WING		0	
FARIBAULT CARE CENTER FARIBAULT, MN 55021 (%) ID PHEFX TWA IBAULTONY OF DEFICIENCIES IRCOLLATIONY OF DEFICIENCIES IRCOLLATIONY OF USO DEFINITION IRCOLLATIONY OF USO DEFINITIONS INFORMATION PHEFX PREFX TWA PROVIDER & RAN OF CORRECTION IRCOLLATIONY OF USO DEFINITIONS INFORMATION F 246 Continued From page 19 R4 was on her way to the beauty shop and did not have her hearing aldes in. The social service F 246 designee (SSD) was questioned about the hearing aldes and did not have a missing item or concern form and was not aware the right hearing alde was missing. About 1 p.m. the SSD said she found the hearing aldes in the medication cart and put them in R4's ears and she can hear now, they are working just fine. Al 300 c.m. R4 was interviewed and stated. This is not the new one, (pointing to night and thought R4 thad the hearing aide is the medication cart atack, through accelent, transient ischemic atack, through actual accident, transient ischemic atack, through accelent is an waring whearing aktes prior to the start of an activity. Furthermore, the plan of care revised 710113, read, "h	NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, ST		
CALL DEARBAULT, MN 35021 PREFX SUMMARY STATEMENT OF DEFIDENCIES (2ACH DEPICIENCY MUST BE PREDEDED BY FULL TAG Deprovembers FLAN OF CORRECTION (2ACH DEPICIENCY MOLTS BE PREDEDED BY FULL TAG PROVEMBER FLAN OF CORRECTION SHOULD BE DROSS REFERENCE TO THE APPROPRIATE DEFIDENCE TO THE APPROPRIATE DEFIDENCE DOTATION FOR LOCATION OF DEPIDENCIES MB F 246 Continued From page 19 R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p. m. The SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. At 3:00 p.m. R4 was interviewed and stated. This is not the new one, (pointing to right ear) these are my old hearing aides that dom two?". R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide last week. 16 R4's sactive diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to coreforal vascular accident, traisient itchemic attack, thyroid disease, and hearing loss both ears. 16 R4's Brief Interview for Mental Status (BIMS) dated 12/29/13, indicated asummary score of 9 out d a possible To for cognitive patterns indicating moderate impairment. 16 R4's plan of care dated 12/2/13, directed staff, 11 am at risk tor social isolation because 1 am hard of hearing. Make certain 1 am wearing my hearing aides prior to the start of an activity. Furthermore, the plan of care revised 7/10/13, read, 1 have extensive hearing loss. Potential					1738 HULETT AVENUE NO	ORTH	
Price CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE Code#Liftion Date F 248 Continued From page 19 F F 246 F 246 designee (SSD) was questioned about the hearing aides in. The social service F 246 F 246 designee (SSD) was questioned about the form and was not aware the right hearing aide and did not have a missing item or concern form and was not aware the right hearing aide was missing 1000 p.m. RH was interviewed and stated, "This is not the new one, (poining to right ear) these are my old hearing aide the art hear mow, they are working just fine. At 300 p.m. RH was interviewed and stated, "This is not the new one, (poining to right ear) these are my old hearing aide the hearing aide was missing and thought R4 had the hearing aide was missing and thought R4 had the hearing aide was missing and thought R4 had the hearing aide tast week. 113 R4's active diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. 114 R4's plan of care dated 12/30/13, directed staff, "I am at risk for social isolation because I am hard of hearing dides in the redicide staff, "I am at risk for social isolation because I am hard of hearing aides prior to the rearing tais. 116 R4's plan of care dated 12/3/13, cliected staff, "I am at risk for social isolation because I am hard of hearing aides prior to the rearing tais. 116	FARIBA	JLT CARE CENTER			FARIBAULT, MN 55021	1	
R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just line. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor, Interview with RN-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide law exek. R4's active diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. R4's Brief Interview for Mental Status (BIMS) dated 12/30/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "1 am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "1 have station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRECT) CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIATE	COMPLETION
 hearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she found the hearing aides in the medication cart and put them in R4's ears and she can hear now, they are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (polning to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with Rh-A verified she did not know the hearing aide was missing and thought R4 had the hearing aide was missing and thought at the hearing aide was missing and thought at a surveyor. Interview with Rh-A verified she did not know the hearing aide last week. R4's active diagnosis from the minimum Data Set (MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. R4's Brief Interview for Mental Status (BIMS) dated 12/29/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 710/13, read, "I have certain I am wearing loss both earing. Make certain I am wearing loss Potential for impairment." The interventions read, "I want my hearing lass left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and 	F 246	R4 was on her way not have her hearin	to the beauty shop and did g aides in. The social service	F2	246		· · · · ·
(MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. R4's Brief Interview for Mental Status (BIMS) dated 12/30/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." The interventions read, "I want my hearing aids left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and	на с 1975 г. 1976 г. 1977 г.	hearing aides and o concern form and v aide was missing. A found the hearing a and put them in R4 they are working ju- interviewed and sta (pointing to right ea aides that don't wor surveyor. Interview know the hearing a	did not have a missing item or vas not aware the right hearing About 1 p.m. the SSD said she tides in the medication cart 's ears and she can hear now, st fine. At 3:00 p.m. R4 was tted, "This is not the new one, r) these are my old hearing 'k." R4 was not able to hear with RN-A verified she did not ide was missing and thought				
dated 12/30/13, indicated a summary score of 9 out of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "I am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." The interventions read, "I want my hearing aids left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and		(MDS) form dated to cerebral vascular attack, thyroid disea	12/29/13, lists but is not limited r accident, transient ischemic				
am at risk for social isolation because I am hard of hearing. Make certain I am wearing my hearing aides prior to the start of an activity". Furthermore, the plan of care revised 7/10/13, read, "I have extensive hearing loss. Potential for impaired communication R/T hearing impairment." The interventions read, "I want my hearing aids left in my room at night and not taken to the nurses station for safe keep. Staff educated me on the risk and benefits of not keeping them locked up at night and the loss and		dated 12/30/13, ind out of a possible 15	icated a summary score of 9 for cognitive patterns				
educated me on the risk and benefits of not keeping them locked up at night and the loss and		am at risk for socia of hearing. Make ce aides prior to the st Furthermore, the pl read, "I have extens impaired communic impairment." The in hearing aids left in r	I isolation because I am hard ertain I am wearing my hearing art of an activity". an of care revised 7/10/13, sive hearing loss. Potential for cation R/T hearing nterventions read, "I want my my room at night and not				
		educated me on the keeping them locke	e risk and benefits of not d up at night and the loss and	1	Facility ID: 00080	lf construction of	t Dago 20 st 20

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If continuation sheet Page 20 of 82

		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED	
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	0938-0391 E SURVEY PLETED	
	:	245097	B. WING			03/1	C	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 246		ge 20 facility. I wear bilateral hearing n in and take them out	Fź	246				
	independently. I will especially with takir on the plan of care again attempted to aides kept in nurse. Resident rejected th losing hearing aide: anything from resid assuring hearing aid The consultation re 7/16/13, under reco plan from nursing h hearing aids will be with replacement. F aide fitting." The co audiology dated 9/3 wearing both aides batteries weekly, ea size 13 or orange a blue). 3. Turn hearing opening battery doo hearing aide recheo problems." A docum and dated 10/4/13, had a size 13 batter tubing was twisted batteries were repla	I ask for assist if I need, ng battery out." An intervention dated 10/25/13, read "Staff have resident allow hearing s cart for safe keeping. he offer. Because of history of s, staff will not remove ents room without first des are accounted for." port from audiology dated ommendations read, "Need ome of how future loss of prevented before patient is fit Return in 2 weeks for a hearing nsultation report from 8/13, read "1. Continue daily. 2. Replacing both arly if needed (the left uses the nd right uses size 675 or ng aids off when not in use by prs. 4. Return in 4 months for a ck, sooner if there are nent titled Audiology office visit read "The right hearing aide ry in it instead of the 675. The on both hearing aides. The aced in both hearing aides are						
	In review of the me for March 2014, the the tracking of the k nursing assistant as "Hearing Aides." bu	dication and treatment sheets ere was no area addressing bilateral hearing aides. The ssignment sheet read, It did not designate the battery nor did the assignment sheet			· · · · · · · · · · · · · · · · · · ·			
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID:477C11		Fac	ility ID: 00989 If continuati	on sheet l	Page 21 of 82	

CENTERS FOR MEDICARE & MEDICAID SERVICES CMB NO. 2038-0391 Partment or percensences (n) movimesuppretencia. (n) movimesuppretencia.<							FORM	03/31/2014 APPROVED 0938-0391
245097 B. WNG 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STATE, ZIP CODE STREET ADDRESS CITY, STATE, ZIP CODE FARIBAULT CARE CENTER SUMMARY STATEMENT OF DEPICIENCES STREET ADDRESS CITY, STATE, ZIP CODE Common Streement Common Streeme	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STHEET ADDRESS, OTM STATE, 2P CODE FARIBAULT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 1738 HULETT AVENUE NORTH FRAIBAULT, MN 55021 IMAGE OF PROVIDERS OF AUXING PREFIX TAG ENUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) FRECULATORY ON LSS DESTIFYING INFORMATION) ID PROVIDERS FLAW, MS 55021 PROVIDERS FLAW, MS 55021 F 246 Continued From page 21 direct staff to account for the hearing aides and the medical record director (MPD) validated the family was difficult to get hold of as neither had answering machines or message capabilities. The MRD did not know if the family was aware of the right hearing aide being missing. SS-DD F 272 F 272 SS-2020(h)(1 COMPREHENSIVE ASSESSMENTS F 272 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. F 272 SSD/0 resident that is either referred to the secured unit will be assessed by SSD/0 rappropriate placement. SSD/0 rappropriate placement. A facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment instrument (RAI) specified by the State. The assessment must include at least the following: Udentification and demographic information; Communication; Vision; Nood and abehavior patterms; Communication; Vision; Mood and behavior patterms; Continnece; Disease diagnosis and health conditions; Dental and nuritional structural problems; Continnece; Disease diagnosis and health conditions; Dental and nuritional structure; Conditions; Activity pursuit;			245097	B. WING	à			
FARIBAULT CARE CENTER FARIBAULT, IMN 55021 (M4)D TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST DE PRICEDED BY PLIL REGULATION OR LSC DEMTIFYING INFORMATION) ID PROVIDERS 2014 COMRECTION BIOLID BY (EACH DEPICIENCY MUST DE PRICEDED BY PLIL REGULATION OR LSC DEMTIFYING INFORMATION) ID PROVIDERS 2014 COMRECTION BIOLID BY (EACH DEPICIENCY MUST DE PRICEDED BY PLIL REGULATION OR LSC DEMTIFYING INFORMATION) ID PROVIDERS 2014 (CMOSS-REFERENCE OT THE APPROPRIATE ODDS AREFERENCE OT THE APPROPRI	NAME OF I	PROVIDER OR SUPPLIER	L					
CMULD PRETRY TAG SUMMARY STATEMENT OF DEFICIENCE (ECA) DEFICIENCY MULT GE PRECEDED BY FULL TAG Deficiency MULT PRECEDED BY FULL TAG PROVIDENT ALL OF DEFICIENCY (ECA) OPPECTIVE ADDO SHOLL DE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY. OWN COMPLETE (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY. F 246 Continued From page 21 direct staff to account for the hearing aides. F 246 F 246 Attempts to call the resident family were unsuccessful to discuss the hearing aides and the medical record director (MRD) validated the family was difficult to get hold as neither had answering machines or message capabilities. The MRD did not know if the family was aware of the fight hearing aide being missing. F 272 AS3.20(b(1) COMPRETENSIVE SS=D ASSESSMENTS F 272 A facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. F 272 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Communication; Vision; Mood and behavior patterns; Psychoscolal well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; F and its will be in substantial compliance by Micro of the secured with the facility's Quality Assurance meetings.	FARIBAL	JLT CARE CENTER						
Preserve TxG CEACH CORRECTIVE ACTION SHOLLD BE DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISCIDENTIFYING INFORMATION) PREFX TxG CEACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CEACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CORRECTIVE ACTION SHOLLD BE DEFICIENCY CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CORRECTIVE ACTION SHOLLD BE DEFICIENCY CorrECTION SHOLLD BE DEFICIENCY CorrECTION SHOLLD ACTION SUBJECTIVE ACTION SHO		SUMMARY STA			L		J	(X5)
direct staff to account for the hearing aides. Attempts to call the resident family were unsuccessful to discuss the hearing aides and family was difficult to get hold of as neither had answering machines or message capabilities. The MRD did not know if the family was aware of the right hearing aide being missing. SS=D ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of a resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment must include at least the following: Identification and demographic information; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Activity pursuit; Medications; Activity pursuit; Medications; Dental and nutritional status; Activity pursuit; <td>PRÉFIX</td> <td>(EACH DEFICIENC)</td> <td>Y MUST BE PRECEDED BY FULL</td> <td>PREF</td> <td></td> <td>(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR</td> <td>BE</td> <td>COMPLETION</td>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
 Insuccessful to discuss the hearing aides and the medical record director (MRD) validated the family was difficult to get hold of a neither had answering machines or message capabilities. The MRD did not know if the family was aware of the right hearing aide being missing. F 272 F 272 ASSESMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive accurate, standardized resident assessment of each resident's functional capacity. A facility must make a comprehensive accurate, standardized reproducible assessment of each resident's needs, using the resident assessment information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Stin conditions; Dental and nutritional status; Stin conditions; Activity pursuit; Medications; Activity pursuit; Medications; Special treatments and procedures; Standardized; A facility rust mate a congression of structural problems; Continence; Descare diagnosis and health conditions; Activity pursuit; Medications; Activity pursuit; Medications; Special treatments and procedures; Standardized treatments and procedures; Special treatments and procedures; Standardized trepreserved treatments and procedures; Standardi	F 246	•		F	246			
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.facility.A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;facility.A facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's externally for the secured unit will be assessed by SSDfor appropriate placement.A facility must make a comprehensive assessment of a resident's needs, using the resident assessment must include at least the following: Identification and demographic information; Cognitive patterns; Continence;2. Any resident that is either referred internally or externally or the secured unit will be assessed by SD for appropriate placement.4. Prior to admission to the secured unit, residents will be reviewed by SSD for the criteria specific to the secured unit.5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. Activity pursuit;6. The facility will be in substantial compliance by Special treatments and procedures;6. The facility will be in substantial compliance by Special treatments and procedures;	F 272	unsuccessful to dis the medical record family was difficult answering machine The MRD did not k the right hearing air 483.20(b)(1) COMF	cuss the hearing aides and director (MRD) validated the to get hold of as neither had es or message capabilities. now if the family was aware of de being missing.	F	272	 Resident #45 has be discharged. R45 was referred to the secure unit related to signific flight risk. Resident h 	s ed cant nas	
Special treatments and procedures;		a comprehensive, a reproducible asses functional capacity. A facility must mak assessment of a re- resident assessme by the State. The a least the following: Identification and d Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-I Physical functionin Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit;	accurate, standardized sment of each resident's e a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; r patterns; being; g and structural problems; and health conditions;			 facility. 2. Any resident that is ereferred internally or externally for the sect unit will be assessed SSDfor appropriate placement. 3. Current residents on secured unit have beereviewed by SSD for appropriate placemer 4. Prior to admission to resecured unit, resident will be reviewed by SSD for the criteria specific the secured unit. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in 	ither ured by the en it. the s SD to	
		Special treatments						4/22/14

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245097	B. WING		· · · · · · · · · · · · · · · · · · ·		13/2014
e 4	PROVIDER OR SUPPLIER			17	IREET ADDRESS, CITY, STATE, ZIP CODE 738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Documentation of s the additional asses	ummary information regarding ssment performed on the care	F 2	272			
	Data Set (MDS); ar	he completion of the Minimum d articipation in assessment.					
	by: Based on interview facility failed to asso appropriateness of	NT is not met as evidenced and document review the ess 1 of 1 residents (R46) for placement in the care unit at the time of					
• •		essment for the placement on the locked					
х ,1	11/5/14 directly from initial Preadmission 11/5/13 indicated F management or ins	o the locked dementia unit on n an acute care hospital. The Screening (PAS) dated 846 needed behavior truction, was resistant to d a history of homelessness					
	stated he was only appropriate placem summary dated 11/	on 3/10/14 at 5:06 p.m. R46 50 and felt this was not an ent. The care conference 25/13 indicated R46 had ant to be "locked up"					

Facility ID: 00989

If continuation sheet Page 23 of 82

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		AND HUMAN SERVICES				FORM	0: 03/31/2014 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		245097	В. WING				C /13/2014
NAME OF F	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CO	Contraction of the local division of the loc	
FARIBAU	ILT CARE CENTER			FARIBAULT, I	VENUE NORTH WN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	VIDER'S PLAN OF CORF CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272		ge 23 mum Data Set (MDS) dated i had a BIMS (brief interview	F 2	272			
	for mental status) s impairment. The M hallucinations, no d physical or verbal b	core of 13/15 or no cognitive IDS noted R46 displayed no elusional behaviors, no ehaviors, displayed no nd displayed no wandering					
	placement at the Fa appropriate for long unit; an elopement facilities to look for not include interven for continued place unit. Review of the	a problem dated 11/6/13 of aribault Care Center was term care; on the secured risk; had a history of leaving alcohol. The care plan did tions related to re-assessment ment on the locked dementia documentation revealed no s had occurred since					La 2014 Con PLAN (C) Con et M Con et M
	administrator (ADM why R46 was in the because he was an	on 3/10/14 at 6:30 p.m. the) stated that she was not sure dementia unit except elopement risk. ADM stated s was an appropriate					
	direct of nursing (D could climb out eve	on 3/13/14 at 12:10 p.m. the ON) stated she believed R46 n with the locked fenced area. ould like to see R46 in an age					
F 279	social service desig to find any social se to dementia unit pla		F 2	279			
OBM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:477C1	1	Facility ID: 00989	lf cc	ontinuation shee	L Page 24 of 82

STATEMENT OF GENERATION (M) PERMETRIATION NUMBER: AND PLAYOF COMPLETED (M) PERMETRIATION NUMBER: A BUILDING (M) PERMETRIATION PERMETRIATION NUMBER: PERMETRIATION NUMBER: PERMET			AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
245997 B. WNG 03/13/2014 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, Z/P CODE Trag HULET AVENUE NORTH STREET ADDRESS, CITY, STATE, Z/P CODE Trag HULET AVENUE NORTH FARIBAULT, MN 55021 Comments Comment	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		COMPLETED
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CTV, STATE, 24 CODE FARIBAULT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 CALL SUMMARY STATEMENT OF DEFICIENCIES. (EACH OERCINCY MUST BE PRACEDED BY PULL REGULATORY ON LSC DENTRY ING INFORMATION) PROVIDERS YEAR OF CONRECTION REGULATORY ON LSC DENTRY ING INFORMATION) PROVIDERS YEAR OF CONRECTION (EACH OERCINCY ACTION SHOLD BE CONSERPETENCIED TO THE APPROPRIATE DEFICIENCY) CM F 279 Continued From page 24 (SS-D) F 279 F 279 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. F 279 The facility must develop a comprehensive assessment. F 279 I.R70 was discharged from the facility to assisted living facility, R40 care plan was reviewed and updated as needed. R27 parameters have been added to care plan as well as non- pharmacological interventions. P279 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being as required under \$483.10, including the right to refuse treatment under \$483.10(b)(4). F 279 This REQUIREMENT is not met as evidenced by: massed on interview and document review, the facility failed to develop a plan of care for 2 of 3 residents (R40, R27) reviewed for unnecessary medications. 3. Director of Nursing/designee will complete an audit of all care plans. 4. Interdiscipinary Team will montor al careplans or car			245097	B. WING _		-
FARIBAULT CARE CENTER FARIBAULT, MN 55021 IMAID PREFIX TAG Summary statement of Deficiencies (Each Deficiency MUST BE RECEDED BY FULL RECOLLATIONY ON LSE CENTERYING INFORMATION) Image: Continued From Page 24 COMPRETEX TAG PREFIX PREFIX TAG PREFIX PREFIX PREFIX PREFIX PREFIX Continued From Page 24 COMPRETEX STORE STORE ACTIONS HOLD BE COMPRETEX STORE	NAME OF F	PROVIDER OR SUPPLIER		· ·		
PREFX TAG REAL CORPORTING ACTION ON SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENTION ON DEFICIENCY F 279 Continued From page 24 SS-D F 279 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. F 279 The facility must develop a comprehensive care plan for each resident that includes medicat, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. F 279 The care plan must describe the services that are to be furnished to attain or maintain the residents highest particulable physical, mental, and psychosocial well-being as required under \$483.20; oncluding the right to refuse treatment under \$483.10; (b)(4). F 279 This REQUIREMENT is not met as evidenced by: medications. F 279 This REQUIREMENT is not met as evidenced by: residents (R40, R70) identified as a fall risk, failed to develop a plan of care for 2 of 3 residents (R40, R27) reviewed for unnecessary medications. S Director of Nursing/designee educated 03/25/14 all nursing staff on updating careplans. 1. Interreficiciplinary Team will monitor all careplans with any change in condition, quarterly and with annual assessment. S. Intercorr of Nursing/designee educated 03/25/14 all nursing staff on updating careplans. Findings include: F 279 S Conter of Nursing/designee	FARIBAU	JLT CARE CENTER				
SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. F279 The facility must develop a comprehensive care plan for each resident fits includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. F279 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.10, including the right to refuse treatment under \$483.10 (b)(4). Director of Nursing/designee will complete an audit of all care plans to ensure that falls and non- pharmacological interventions for unnecessary medications have been addressed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care for 2 of 3 residents (R40, R70) identified as a fall risk, failed to develop aplan of care for 2 of 5 residents (R40, R70) reviewed for unnecessary medications. 4. Interdisciplinary Team will monitor all careplans with any change in condition, quarterly and with annual assessment. 5. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25; and any services that would otherwise be required under \$483.25; and any services that would otherwise be required under \$483.10, including the right to refuse treatment to develop a		-		F 27	9	
		to develop, review a comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including under §483.10(b)(4) This REQUIREMEN by: Based on interview facility failed to dev residents (R40, R7 to develop a plan o non-pharmacologic residents (R40, R2 medications. Findings include:	and revise the resident's n of care. evelop a comprehensive care ent that includes measurable itables to meet a resident's nd mental and psychosocial tified in the comprehensive t describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment .). NT is not met as evidenced v and document review, the elop a plan of care for 2 of 3 0) identified as a fall risk, failed f care that included al interventions for 2 of 5 7) reviewed for unnecessary		 1.R70 was discharged from the facility to assisted living facility, R40 care plan was reviewed an updated as needed. R27 parameters have been added to care plan as well as non-pharmacological interventions. 2. Director of Nursing/designee complete an audit of all care plan to ensure that falls and non-pharmacological interventions for unnecessary medications have been addressed. 3. Director of Nursing/designee educated 03/25/14 all nursing st on updating careplans. 4. Interdisciplinary Team will monitor all careplans with any change in condition, quarterly ar with annual assessment. 5.If any issues are identified it w be addressed through the facility Quality Assurance meetings. 6. The facility will be in substanti 	d will ns or aff ill i's

PRINTED: 03/31/2014

		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE COMI	E SURVEY PLETED
		245097	B. WING	à		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279		ge 25 6:45 p.m. and on 3/9/14 at	F	279			
	initiation date of 1/1 1/20/14 revealed th	of care for R70 with an 0/14, and a revision date of at there were no goals or ssing falls or falls with					
- 144 m 天明 15 - 15 m	Set (MDS) form da limited to, hyperter weakness. The MD falls with fracture 2	osis from the minimum Data ted 1/16/14, lists but is not nsion, anxiety and muscle S further indicated a history of -6 months prior to admission. essment addresses falls as a					2 (V 10 2 (V 10 2 (2 (V 10) 2 (2 (V 10) 2 (2 (V 10) 2 (2 (V 10)) 2 (2 (V 10))) 2 (2 (V 10))) 2 (2 (V 10))) 2 (2 (V 10))) 2 (2 (V 10)))
	dated 1/16/14, indi	w for Mental Status (BIMS) cated a summary score of 14 5 for cognitive patterns ly intact.					
	director of nursing risk with fracture pr	on 3/12/14, at 11:30 a.m. the (DON) verified R70 was a fall ior to admission, and R70 had a fall risk, which should have n the plan of care.					
	which included (on of falls, intracerebra hydrocephalus, sch agitans, and comp The resident's initia Set dated 1/17/20	Al Admission Minimum Data					
EODM CMS 2	total assist of 1-2 s	ly impaired with extensive to taff. The resident had a .0's initial care plan (with date s Obsolete Event ID:47701	1	Fa	cility ID: 00989	ion sheet l	Page 26 of 82

	TH AND HUMAN SERVICES	•		FORM	03/31/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
	245097	B. WING			C 13/2014
NAME OF PROVIDER OR SUPPL	IER	1	STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
FARIBAULT CARE CENTE	R		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 279 Continued From initiated 1/14/20 history of falls a	n page 26 14) did not address the resident's nd did not address interventions.	F 2	79	÷	
A fall risk asses reviewed. It ide falls in the last 9 had periods of a surroundings, m and always nee neuromuscular assessment ind higher risk for fa On 3/13/2014 a nursing was inte plan (on admiss	sment dated 1/11/2014 was ntified the resident with 3 or more 00 days, resident's cognitive statu altered perception or awareness of nobility was confined to wheelchai ding physical support. R40 had a or functional loss. The icated the resident was at a	S f I			
use of an anti-a address use of interventions pr anti-anxiety me scheduled psyc	are did not address parameters fo nxiety medication and did not non-pharmacological ior to the administration of dications. R27 was on multiple hotropic medications, which were on the plan of care.		•		
altered mental s toes, sedative/h nondependent o hypertension, e dependence ab drug-induced ps	/3/2014 with dx (from care plan) status, traumatic amputation of ypnotic /anxiolytic dependence, cannabis abuse, diabetes, sophageal reflux, opioid type use, dissociative identity disorder sychotic disorder with baranoid schizophrenia,	,			
on Clonazepam severe anxiety.	er dated 2/3/2014 identified R27 0.5 mg twice daily as needed for The other scheduled edications were Buspar, Elavil,		Facility ID: 00989	If continuation sheet	Page 27 of 82

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		245097	B. WING	ì			13/2014
NAME OF F	PROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE, ZIP CODE 738 HULETT AVENUE NORTH		
FARIBAU	JLT CARE CENTER				ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa Zyprexa, and Trilaf	-	F	279			м ² н
	reviewed. The resi clonazepam (antiar	dated 2/2014 and 3/2014 were ident used the as needed nxiety medication) several ns. The scheduled other					
		cations were given as ordered.					
	of 2/20/2014 was re documentation rega necessary anti-anx address what non p	iated 2/5/2014 and print date eviewed. The care plan lacked arding the use of the as iety medication and did not pharmacological interventions					
	anxiety medication.	efore giving the as needed anti					1. a 2 ³ Najaran - 1
	non-pharmacologic	also lacked documentation of al interventions attempted stration of as necessary tion.					
	interviewed regardi antianxiety medical pharmacological in	2:50 p.m., the DON was ng use of as necessary (prn) tion and stated that non terventions should be					
- 	medication. DON s have been develop	he as needed anti anxiety tated the care plan should ed to identify the use of the I the non pharmacological					
en.							
	needed antianxiety anxiety, monitoring						
	non-pharmacologic administration of th	al interventions prior to e medication.					
	A Discharge summ	ary from the hospital dated					

;

		AND HUMAN SERVICES				FORM	: 03/31/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245097	B. WING				C 13/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279		ge 28 R40 used as needed ety and every bedtime for	F	279			
	falls, schizoactive d compression of bra alcohol use, intrace	2014 with diagnoses hx of lisorder, paralysis agitans, in, parkinson's disease, hx of rebral hemmorrhage, phalus, insomnia (on MD				j.	11 2014
, Mar Bita Anti-	Lorazepam 0.5 mg needed for anxiety;	ated 1/16/2014 identified by mouth every 6 hours as and Lorazepam 0.5 mg (4 outh at bedtime as needed for					
	Lorazepam (antian)	heets were reviewed: xiety medication) was used as and/or anxiety: 1/149 aed 23 times and in 3/14-it					
	reviewed. It identifie staying asleep; rela history of taking sle to bedtime. An aver	dated 1/13/2014, was ed the resident had difficulty ted to pain; did not have a ep medications routinely prior rage length of nap was 1-2 urological deficits (stroke,					
	Parkinson's disease environmental facto sleeping difficulties assessment was a	e, seizure disorder). No ors contributing to resident was identified. The collection of data but did not or analysis of the data to					
	and print out date o	h initiated date of 1/14/2014 f 2/20/2014 was reviewed. It 0's sleep issues or use of as					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: 477C1	1	Fac	ility ID: 00989 If continu	ation sheet	Page 29 of 82

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

PRINTED: 03/31/2014 FORM APPROVED OMB NO. 0938-0391

				LE CONSTRUCTION	T	E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
						C C
		245097	B. WING		03/	13/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 738 HULETT AVENUE NORTH		a di sana
FARIBAL	JLT CARE CENTER			ARIBAULT, MN 55021		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
1.20 s						Maria di Kalendari d Kalendari di Kalendari
F 279	Continued From pa	-	F 279			
		medications. The care plan ion regarding what non				
	pharmacological in	terventions should be				
	attempted before gi anxiety medication.	iving the as needed anti				
	non-pharmacologic	also lacked documentation of al interventions to be he administration of				
	assistant (TMA)-C v of the antianxiety m she did not give the	:45 a.m., a trained medical was interviewed regarding use nedication. TMA-C indicated medication during the day was given the medication at				
	used it throughout t was up and about.	esident got anxious but rarely he day because the resident The TMA did not know if there prior to giving the medication.				n an
	DON was interview antianxiety medicat be using non pharm to administering the be following up for o	:50 p.m. and 1:05 p.m., the ed regarding criteria for use of ion. She stated they should nacological interventions prior e medication and should also effectiveness. DON also				
F 282 SS=D	indicated it was not the sleep plan for R assessment data.	nonitoring for R40 and being done, DON said that 840 was not based on sleep RVICES BY QUALIFIED ARE PLAN	F 282			
an 1995 - 19		led or arranged by the facility y qualified persons in				

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

Event ID: 477C11

Facility ID: 00989

If continuation sheet Page 30 of 82

		AND HUMAN SERVICES			FORI	D: 03/31/2014 MAPPROVEE D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION (X3) DA	TE SURVEY
		245097	B. WING		03	C 3/13/2014
NAME OF I	PROVIDER OR SUPPLIER	.	I		TREET ADDRESS, CITY, STATE, ZIP CODE	
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021	
(X4) ID PREFIX - TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282		ge 30 ich resident's written plan of	F 2	282		
	This REQUIREME	NT is not met as evidenced				
	review the facility fa was followed for 1 of with urinary incontin	tion, interview and document ailed to ensure the care plan of 3 residents (R25) observed nence and 1 of 3 residents assistance with hearing aides.		-	F282 1.R25 is deceased, R4 hearing aid was found immediately when it was reported missing, hearing aid was in working order. 2. Interdisciplinary Team will audit	
	accordance with the	e incontinence care in e plan of care. During three tinence care exceeded the 2 ne care plan.			all direct care care plans to ensure they are accurate for activities of daily living. 3. Director of Nursing/designee educated 03/25/2014 all staff on	
	care plan had a foc toileting" and direc 2 hours and per rec	ed 2/13/14 was reviewed. The us of, "staff assist with ted staff to offer toileting every quest. On 2/13/14 a change are plan that directed a check ule.			following the direct care careplan. 4. Director of Nursing/designee will complete weekly random audits to ensure staff is proving care as directed on direct care careplan. 5.If any issues are identified it will	
	observed to be lyin two soaker pads ur observed to be pro 3.5 hours. On 3/12 10:25 a.m. to 1:30 be provided contine	00 pm to 7:30 p.m.R25 was g on his back in bed. R25 had ider him. R25 was not vided incontinence cares for 2/14 R25 was observed from p.m. R25 was not observed to ence cares for 3 hours. NA)-J stated she had last			be addressed through the facility's Quality Assurance meetings. 6. The facility will be in substantial compliance by 04/22/2014	4/22/14
	repositioned and as total of 3.5 hours. at 12:00 p.m. to 1:3 received incontiner	ssisted R25 at 10:00 a.m. or a R25 was observed on 3/12/13 30 p.m. At 1:30 p.m. R25 ace care (by observation 1.5 d she had last provided cares			sility ID: 00989	

It continuation sheet Page 31 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 03/31/2014 M APPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		245097	B. WING	· · · · · · · · · · · · · · · · · · ·	0	3/13/2014
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		ZIP CODE	
FARIBA	JLT CARE CENTER	\ \		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	to R25 at 10:00 a.m	ge 31 1. (a total of 3.5 hours) On Diserved from 7:09 a.m. to 8:58	F 2	82	· · · ·	
	a.m. and no incont NA-C stated she ha	inence cares were provided. Id worked all night and had epositioned R25 at 5:30 a.m.				
1 0+ - 05 - 1	3/13/14 at 11:45 a.r expect the care pla resident refused ca re-approach for car	ing (DON) was interviewed on n. DON stated she would n to be followed. If the res, she would expect staff to es. DON stated she had not staff related to R25 refusing to e cares.				
		assistance with hearing aides ding to the plan of care.	х х			
	directed staff, "I am because I am hard wearing my hearing activity". Furthermo 7/10/13, read, "I ha	n of care dated 12/3/13, at risk for social isolation of hearing. Make certain I am g aides prior to the start of an re, the plan of care revised ve extensive hearing loss. ed communication R/T hearing				
	7:00 p.m. R4 was of able to hear despite present in the left e the missing hearing not know what the or replacing the hear NA-B came into the did not know what I or why the one in the	and interview on 3/10/14, at omplaining about not being a having a hearing aide ar. R4 said she had reported aide to her right ear, but did acility was doing about finding aring aide. Nursing assistant or oom and when questioned happened to the hearing aide he left ear was not working. o you communicate NA-B		Facility ID: 00989	If continuation shee	

Event ID:

If continuation sheet Page 32 of 82

		AND HUMAN SERVICES				FORM): 03/31/2014 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO		(X3) DA	TE SURVEY MPLETED
		245097	B. WING			03	C /13/2014
NAME OF I	PROVIDER OR SUPPLIER	L			S, CITY, STATE, ZIP C		
FARIBAL	JLT CARE CENTER			1738 HULETT AV FARIBAULT, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	VIDER'S PLAN OF COF CORRECTIVE ACTION EFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282		ige 32 s and stated, "We make it er." The nursing assistant	F 2	82			
	attempted to chang could not hear the	e the battery for R4 but R4 conversation which surveyor mputer for R4 to read and			•		
	R4 was on her way not have her hearin designee (SSD) wa hearing aides and o concern form and w aide was missing. / she found the hear	ion on 3/13/14, at 11:50 a.m. to the beauty shop and did ng aides in. The social service as questioned about the did not have a missing item or vas not aware the right hearing About 1:00 p.m. the SSD said ing aides in the medication n R4's ears and she can hear ing just fine.			•		
	stated, "This is not ear) these are my c	p.m. R4 was interviewed and the new one, (pointing to right old hearing aides that don't able to hear surveyor.					
F 285 SS=D	hearing aide was m hearing aide last w	A verified she did not know the hissing and thought R4 had the eek. (e) PASRR REQUIREMENTS	F 2	185			
	pre-admission scre program under Me	dinate assessments with the ening and resident review dicaid in part 483, subpart C to nt practicable to avoid and effort.					
	January 1, 1989, a	ust not admit, on or after ny new residents with: as defined in paragraph (m)(2)					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: 477C1		Facility ID: 00989	lf c	continuation shee	t Page 33 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES		×		FORM	03/31/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245097	B. WING			1	C 13/2014
NAME OF	PROVIDER OR SUPPLIER		A	STREET AI	DDRESS, CITY, STATE, ZIP CODE		
FARIBA	JLT CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021			
PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DÉFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 285	Continued From pa (i) of this section, un authority has deterr	nless the State mental health	F	285 F285	5		
	performed by a per State mental health (A) That, becaus condition of the indi	al and mental evaluation son or entity other than the authority, prior to admission; e of the physical and mental vidual, the individual requires			 R46 has been discharge R27 Social Service Designee has called the Senior Linkage Line for 	•	
	the level of services and (B) If the individu services, whether the specialized services (ii) Mental retardat (m)(2)(ii) of this sector retardation or devel has determined priot (A) That, becaus condition of the individu services, whether the specialized services For purposes of this	s provided by a nursing facility; al requires such level of ne individual requires s for mental retardation. tion, as defined in paragraph tion, unless the State mental opmental disability authority or to admission e of the physical and mental vidual, the individual requires s provided by a nursing facility; al requires such level of ne individual requires s for mental retardation.		3	 further assessment The Social Designee will complete audits of all net admissions within last 9 days to determine the required PSARR has be completed Social Service Designee has been educated 04/17/2014 regarding the requirements related to the PSARR Social Service Designee will complete audits of all new admissions If any issues are identifie 	II ew en e e	
	illness" if the individ illness defined at §4 (ii) An individual is retarded" if the indiv defined in §483.102 related condition as	considered to have "mental ual has a serious mental 483.102(b)(1). considered to be "mentally vidual is mentally retarded as 2(b)(3) or is a person with a described in 42 CFR 1009.		6.	it will be addressed through the facility's Quality Assurance meetings.		4/22/14
	Based on interview			Facility ID: 009	·····		Page 34 of 82

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			PR		03/31/2014 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			ON	<u>18 NO.</u>	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COM	E SURVEY PLETED
		245097	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		()/(5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 285	Continued From pa	ao 24		0.5			
1 200		pleted for 2 of 3 residents	F 2	:85			
	(R46, R27) reviewe						
	illness/developmen						
	Findings include						
	R46 lacked a PSAF admission.	R level II evaluation on					
	hospital to the facilit R46's diagnoses lis screening dated 11/	on 11/5/13 from an acute care y ' s locked dementia unit. ted on the preadmission 5/13 as Karsakoff dementia mentia) and bipolar disease.					
	submitted on Nover LinkAge Line The Result as: "Based for this nursing hom meets the criteria for	ssion Screening (PAS) was nber 5, 2013 by Senior PAS noted OBRA Level I on the information provided e stay, it appears this person r MI and needs to be referred or further evaluation. "					and Sanata Sanata Sanata Sanata Sanata
	3:05 p.m. and stated PSARR screening in	as interviewed on 3/13/14 at d that she had no further nformation and was presently ask for a level II screening.					
	R27 lacked a PSAR admission.	R level II evaluation on					
	had diagnoses listed	o the facility on 2/3/2014, and d on the preadmission /2014 as altered mental nrenia.					
	submitted on Februa	ssion Screening (PAS) was ary 3, 2014 by Senior LinkAge ted OBRA Level I Result as: "					

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Facility ID: 00989

If continuation sheet Page 35 of 82.

		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED
		245097	B. WING	i			0 13/2014
NAME OF F	PROVIDER OR SUPPLIER	· · ·			TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		1. 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285		ige 35 nation provided for this nursing ars this person meets the	F	285	F309 1.R39 care plan reviewed and		
F 309	criteria for MI and r agency for further e On 3/13/2014 at 3:0 provided a copy of completed by the c the facility on 2/4/20 documentation that level 2 screening at Administrator indica PASRR screening to The level 2 screening	needs to be referred to the lead evaluation." 00 p.m., the Administrator the PASRR documentation ounty which had been faxed to 014. However, the twas provided did not have the ttached. Interview with the ated there was only the level 1 that had been completed . ng was not provided. CARE/SERVICES FOR	F	309	updated-to-reflect-non- pharmacological interventions for pain management, R46 has been discharged from the facility, R29 care plan reviewed and updated reflect non-pharmacological interventions for pain management, R25 is deceased. 2. The DON/designee will complete an audit of all resident pain assessment and development of care plans for pain. The DON/designee will complete an	en) I to 's	
	Each resident must provide the necess or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat review, the facility f care and services w assessment, develo monitoring related residents (R39, R4	t receive and the facility must ary care and services to attain hest practicable physical, bsocial well-being, in e comprehensive assessment NT is not met as evidenced tion, interview, and document ailed to ensure the necessary were provided, based on opment of a care plan, and to pain management for 3 of 3 6, R29) who were reviewed for lent (R25) who was reviewed			audit of all resident's pain management to ensure proper monitoring is being completed. The DON/designee will complete an audit on all resident in wheel chairs to ensure that proper positioning is being obtained. 3. The DON/Designee educated 03/25/14 all licensed nursing stat on facility policy and procedure o pain management to include assessment, care plan development and monitoring. The DON/designee will educate therapy department on wheel cha positioning document that will be completed upon admit, quarterly,	ff on le air	
	Findings include:				annually and with significant change.		

Event ID: 477C11

Facility ID: 00989

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY IPLETED
		245097	B. WING			C 13/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 36	F 309			
		ing migraine headache pain		309 continued		
	to develop effective interventions to mir identify which as no be used, document pain medication wh On 3/10/2014 at 6: nurse for pain medication the bedroom doorw nurse shut the light would get some or 6:49 p.m., the resid in the chair and the migraine and would time but maybe tor medical assistant (with the medication R39 the requested migraine. At 7:10 p and stated she wa request (40 minute it), as she was on h ask R39 what the she would check a have it. At 7:15 p.r said the last time th at 1:45 p.m. and co received it every 6 have oxygen on co The TMA indicated 7:45 p.m. then cou 2 tabs. The TMA so out why R39 was g requested pain me	30 p.m., R39 was looking for a lication. R39 was standing in vay with the call light on. The toff and told the resident she check on the medication. At dent was sitting in the bedroom a resident indicated had a d rather not interview at that norrow. At 7:00 p.m. a trained TMA)-C went down the hall n cart but didn't stop to give pain medication for the b.m., TMA-C was interviewed us just told about the Tylenol as after the resident requested oreak, and she was going to pain medication was for and nd see if the resident could m., TMA-C came back and he resident had the Tylenol was puldn't have it because hours. R39 was suppose to ontinuously but wouldn't do it. I the resident had to wait til lid have the Tylenol ES 500 mg stated they are trying to figure getting the migraines and odication every night at this cological interventions were not		 4. The IDT/designee will monito pain assessment and care plan development for pain quarterly using the care plan check list. T DON/designee will audit pain monitoring 3 times a week using the nursing management compliance document. The IDT/designee will monitor the completion of the wheel chair positioning document quarterly using the care plan check list. 5. If any issues are identified it w be addressed through the facility Quality Assurance meetings. 6. The facility will be in substantia compliance by 04/22/2014 	'he 'ill	4/22/11

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	03/31/2014 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			الالاية بالمحمد المتشاعدة والمحمد المحمد المحركة والمتحد معتمر معترات والمحمد معتمل مواصلات والمترك والمتكاف والمتقا المتعط	1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION		E SURVEY PLETED
			A. BUILD	ind.			c
		245097	B. WING				13/2014
NAME OF F	PROVIDER OR SUPPLIER	L	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	JLT CARE CENTER				738 HULETT AVENUE NORTH		
			,	F	ARIBAULT, MN 55021		· . · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
					DEFICIENCY)	****	1 A 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
F 309	Continued From pa	age 37	F3	309			
	On 3/11/2014 at 8:0	00_a.m., R39_was_observed					
	sitting in the dining	room and stated didn't take					
	bath today and was	s short of breath. At 10:00					
	a.m., was observed	d up and about without oxygen in the lobby without oxygen on.					
	At 11:50 a.m., was	observed resting in bed with					
	the lights off. At 1:	20 p.m. was in bed resting and					
	requesting a pain n	nedication for headache. Non terventions were not offered or					
	attempted.						
	On 3/12/2014 at /:	45 a.m., R39 up and sitting on 20 p.m. in lobby, looking out					
	the window, and s	tated feeling better today, and			•		
	had Tylenol for a he	eadache. At 3:20 p.m., R39					ing the second s
	was in bed in darke	ened room resting.					
	On 3/13/2014 at 8:	00 a.m., R39 was out of room					21 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
	and at 9:00 a.m. w	as in room laying on the bed					
	resting. At 11:46 a	.m., the resident was up being outside and would not					
	respond when spol						
	R39 was readmitte	d to the facility on 6/12/2013 ch was listed in the medical					•
	diagnoses on the c	computer and included: chronic					
	obstructive pulmon	nary disease, hepatitis C					
		ease, esophageal reflux, aine abuse, drug-induced					
		a, and hypertension.					
	A quarterly Minimu	m Data Set (MDS) dated d the resident with moderate					
		ent, on a pain medication					
	regime, received a	s necessary pain medications,					
	and occasional pai	in affected activities and sleep.					
		e pain was rated as 8. A MDS dated 2/7/2014, identified					
FORM CMS-2	567(02-99) Previous Version			Fa	cility ID: 00989 If continua	tion sheet	Page 38 of 82

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		AND HUMAN SERVICES			FOR	MAPPROVED
	AS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	VG	C0	OMPLETED
	•	245097	B. WING _	×	0	C 3/13/2014
NAME OF F	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, S		
FARIBAU	JLT CARE CENTER			1738 HULETT AVENUE N FARIBAULT, MN 5502		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 309	scheduled pain reg	tive status as moderate , no ime; as necessary pain	F 30	99		
		pain was present, almost affect sleep or activities. The was rated at 7.				
	The resident was ic type headache, and which was increase recommended. (ac scheduled for 4/2/2 had chronic tension every 6 hours was	ted 2/26/2014 were reviewed. lentified with chronic tension I was on Depakote medication ed. A Neurology consult was cording to staff appointment is 014). 1/29/2014, the resident type headache and Ibuprofen started and Depakote provement with tramadol				
	medication, minima some improvement noted and with ong morphine medicatio	I improvement with Tylenol, with morphine but daily use oing pain. The tramadol and ons were discontinued.				
	and 12/14/2013, bu come up with a sun plan identifying crite which pain medicat non-pharmacologic	t was completed on 7/12 2013 ut the data was not analyzed to nmary of the pain issues, a eria to be used to determine ion to be given and a plan for al interventions to be used. n 3, as necessary, pain				
	following: For 12/2 mg every bedtime; as necessary for h 12/15-12/31) and T hours as necessary used tramadol ever	eets were reviewed for the 013, R39 used Tylenol 1000 tramadol 50 mg every 6 hours eadache used (8x from ylenol ES 500 mg every 6 / for pain; for 1/2014, R39 y 6 hours as necessary 26				
EODM CMS 28	was used 3 x for he	0 mg every 6 hours as needed eadache, acetaminophen 1000 rs as needed used many Obsolete Event ID:477C1		Facility ID: 00989	If continuation she	et Page 39 of 82

PRINTED: 03/31/2014

		AND HUMAN SERVICES				FORM	: 03/31/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	E SURVEY IPLETED C
		245097	B. WING			1	13/2014
NAME OF F	PROVIDER OR SUPPLIER	L			REET ADDRESS, CITY, STATE, ZIP CODE		ł
FARIBAL	JLT CARE CENTER				38 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309		ne sulfate every hour as	F:	309			
	many times. For 2/3 mg daily as necess times; used the ibu and the acetaminop For 3/2014, the ibu	te to severe pain was used 2014, R39 was on Imatrex 100 sary. The resident used it 15 profen medication many times ohen 1000 mg ES many times. uprofen and acetaminophen times as necessary.					
	criteria to identify w which of the many for the resident's pa Non pharmacologic	cal interventions or as needed pain medication			·		
	indicated the follow intermittent headact interferes with my a doesn ' t interfere w ADL's. My pain ma scale. On 10-13 m testing (CD scan of sleep study) and or this. Interventions: relief and respond effectiveness of pa call for assistance. controlled by Topar Ibuprofen. Use of history of poly-subs	h print date of 2/13/2014 ring: I have frequent shes (chronic for me). Pain ability to sleep at times, but with my ability to do my own ay be as bad as 7/10 on a pain y provider ordered extensive f sinus, neurology follow up, nce ordered I refused all of anticipate my need for pain immediately. Evaluate the in interventions, I am able to I prefer to have pain nax, melatonin, Tylenol and narcotics is discouraged due to stance abuse. monitor for side I, prior to administering as			· · · · · · · · · · · · · · · · · · ·		
	necessary Tylenol,	utilize non-pharmacological as ice for my head, relaxation					

Facility ID: 00989

If continuation sheet Page 40 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	Сом	E SURVEY PLETED
		245097	B. WING	à			13/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
				~ ~ ~			
F 309		ge 40 :30 p.m., a trained medical		309	9		
	assistant (TMA)-C-	was_interviewed_regarding_use_					
	of as needed (prn)	pain medications and /A-C stated they are to					
		medication on back of MAR					5 A.A.
		stration record) and					
	completed.	low up, but not always					
		50 mm and 1.05 mm the					
	director of nursing	:50 p.m. and 1:05 p.m., the (DON) was interviewed					
	regarding pain asse	essments and use of as					
		ations. She indicated the pain data collection but an analysis					
	of the data was not	completed to determine a					
	plan. The use of pl medication should	rn (as necessary) pain be documented on the MAR					
	and follow up for ef	fectiveness should be on the					
		e to use a pain management MAR for each resident which					
	included all the con	nponents. When checked, the			· · · · ·		
	MAR's did not have	the pain management forms d the staff were not doing it.					
	There should be cr	iteria related to which pain					
	medication to use a find the criteria.	and when and she could not					
	The DON also state	ed Non pharmacological					
-	interventions should medication adminis	d be attempted prior to the					
-		rehensive pain assessment, re with non-pharmacological					
	interventions for pa	in and lacked monitoring					
	related to pain man	agement.					
		to the facility 11/5/13. The					
		Immary dated 11/25/13 diagnoses that included					· ·
		rsisting dementia, bipolar					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID:477C1	1	F	Facility ID: 00989 If continuat	ion sheet	Page 41 of 82

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			C	FORM MB NO	: 03/31/2014 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		245097	B. WING	à	·		C 13/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	ILT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(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 APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	Continued From pa disorder, and traum	-	F	309			
к - 14 - 14	400 mg 1 tab by mo needed for pain, lid	gned 2/5/14 include ibuprofen outh three times daily as ocaine 5% patch apply 1 patch n for 12-hours off for 12-hours,				· .	
	stated he had pain he had numb feet. was asked if he had ankle and foot num wanted the lidocain stated he had back 10. R46 stated he patch placed on his stay put. R46 was survey 1/10/14 thro	on 3/10/14 at 5:00 p.m. R46 but would not rate it. Stated On 3/13/14 at 7:45 a.m. R46 d pain. R46 stated he had bness and that was where he e patch placed. R46 also pain that he rated at a 7 out of did not want the lidocaine back because it would not observed on all days of the ugh 3/13/14 to transfer come to a stand, and walk					
	reviewed. As needed January for complated documentation of n document the inten non-pharmacologic attempted or if the of The as needed ibug during February. Norecorded four times given for mouth pail pain or if any non-p had been attempted observations indication	ministration record was ed ibuprofen was given twice in ints of back pain. The ursing observations did not sity of the pain or if any al interventions had been medication had been effective. profen was given 6 times lursing observations were s indicating the medication was n but lacked intensity of the harmacological interventions d. Three of the four ted relief. Ibuprofen was					
M	given once during t	he first 2 weeks of March. ns did not record the					· · · · ·

		AND HUMAN SERVICES					FORM	03/31/2014 APPROVED
STATEMENT	TS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		X3) DATE COM	0938-0391 SURVEY PLETED
	,	245097	B. WING	ì			0 3 /1	C 3/2014
	PROVIDER OR SUPPLIER	<u></u>		17	TREET ADDRESS, CITY, STATE, 2 738 HULETT AVENUE NORTH ARIBAULT, MN 55021	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD E THE APPROPRI		(X5) COMPLETION DATE
F 309	reviewed. Pain wa	inistration record was s documented once per shift	F:	309				
	each day. The doc not experience pair The facility's pain a	umentation indicated R46 did ssessment was completed on	<i>у</i> .					
х АК У АК У	experienced pain fr on a scale of 00-10 addressed). The c for pain dated 11/29 experienced pain a the pain was almost findings indicated F	sment indicated the resident equently that was rated at 4 (mild to severe intensity not are area assessment (CAA) 5/13 indicated the resident t a scale rating of 6 and that t constant. The analysis of A46 had pain related to an						
	physician. The CA frequency or intens non-verbal indicato signs and symptom potential causal fac	s being managed by the A did not evaluate the ity of pain, if there were any rs of pain, or any associated is related to the pain, any tor of pain, or the y pain management program.						
	of pain medication administer medicat care did not identify	inted 2/18/14 indicated a focus with an intervention to ion as ordered. The plan of where the pain was located hacological interventions to to manage his pain.			•			
	director of nursing pain medications n location, intensity a she had just update	on 3/13/14 at 12:10 p.m. the (DON) stated with as needed urses were to document pain nd effectiveness. DON stated ed the care plans, but that all nsible for keeping the care						
	plans current. R29 lacked a comp 567(02-99) Previous Versions	orehensive pain assessment			ility ID: 00989	16 marshim and		Page 43 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · ·		NSTRUCTION		COMF	SURVEY PLETED
		245097	B. WING	i			03/1	3/2014
NAME OF F	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZI	P CODE		
FARIBAU	ILT CARE CENTER				IULETT AVENUE NORTH BAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE
F 309	Continued From pa and the developme residents pain.	ge 43 nt of a plan to manage the	F	309				
	R29 was observed R29 was slow to cc bed. R29 's face a her back hurt. R29 burned because of observed during nc p.m. R29 was eatil	on 03/11/2014 at 10:27 AM. me to a sitting position in the ppeared pained. R29 stated also stated that her mouth decayed teeth. R29 was on lunch on 3/12/14 at 12:23 ng a regular diet independently t what she called meat burned.						
	diagnoses listed or record as osteopor and pain. R29 had Acetaminophen 32	to the facility in 2009. R29 had the medication administration osis, depression, dementia, a physician ' s order for 5 mg tablet. 2 tabs by mouth 4 . No as needed medication found.						
	the resident complete intermittently and h R29 had a physicia	umentation of 1/15/14 noted ained of back pain ad a diagnoses of lumbago. n ' s order dated 10/12/11 for lets 2 tabs four times daily.						
	1/13/14 indicated F interview for menta cognitive impairme had pain and that r	used. The frequency and						
	The care area asse was reviewed. The 567(02-99) Previous Versions	essments (CAA) dated 8/5/13 e nutritional status CAA noted			D: 00989	lf posting of		Page 44 of 82

		AND HUMAN SERVICES				FORM	: 03/31/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED C
		245097	B. WING	·			13/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309		ige 44 ck of concentration on the the oral pain." The pain status	F:	309			
	CAA noted : numer and that resident in constantly. The CA Tylenol currently. The facility pain ass	ic rating scale for pain at a 6 dicated she had pain almost A noted pain managed by sessment dated 1/11/14 ain, but stated she experienced				;	
	pain occasionally. of 00-10 at a 3 or m indicated R29 woul when in pain and re The assessment di was located, what w the pain and if an a	R29 rated her pain on a scale nild. The assessment d display facial expression eceived scheduled Tylenol. d not indicate where the pain were potential causal factors of ssessment for the cognitively pain had been conducted.		-			
	reports moderate p arthritis of hips and scheduled use of T as per MD orders a Give PRN meds for medications ordere pains and discomfo complaints and nor care plan lacked no interventions to ass Care plan problem	sist R29 to manage her pain. focus: dental health problems		-			and an Contraction
	as indicated by occ interventions includ for dental care. Mo PRN symptoms of The care plan lack interventions to ass	asional oral pain. The led: coordinate arrangements nitor/document/report to MD oral pain needing attention. ed non-pharmacological sist R29 to manage her oral					
		sing (DON) was interviewed on m. DON stated she was					

Facility ID: 00989

If continuation sheet Page 45 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES			FORI	D: 03/31/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		245097	B. WING		0;	C 3/13/2014
	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, 1738 HULETT AVENUE I FARIBAULT, MN 550	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S I X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	.(X5) COMPLETION DATE
F 309		ge 45 ues, but unaware of the purningDON stated she was	F 3	09		
	not sure the facility cognitively impaired been an issue for F complained of back the care plan shoul	had a pain assessment for the d, but did know that pain had 29. DON stated R29 pain last week. DON stated d be revised as necessary and ow the plan of care.				
	R25 was not provid when in the wheelc meals.	ed appropriate positioning hair or when in bed during				
	7:30 p.m. lying in be elevated. At 6:05 p and the head of the R25 was observed the foot of the bed a he sat in an upright Licensed practical r	on 3/10/14 from 4:00 p.m. to ed with the head of the bed .m. R25 received his meal bed was elevated further. to have feet extended beyond and was not positioned so that position to eat safely. hurse (LPN)-I repositioned the he bed by pulling the resident 2 staff.				
	in bed with head of tray had been provi Registered nurse (F observe the resider was not positioned safely. RN-A left the person to assist wit	RN)-A entered the room to at's position and stated R25 properly to eat the meal proom to find another staff h positioning the resident bed.				
EORM CMS-22	dated 11/7/13 did n positioning and eati printed 2/13/14 ider	essment for nutritional status ot identify R25's safety with ng in bed. The care plan ntified a focus/problem of need nterventions included assist of Obsolete Event ID:477C11		Facility ID: 00989	If continuation shee	+ Page 46 of 90

	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	1	. 0938-0391 re survey		
	F CORRECTION	IDENTIFICATION NUMBER:	1	IG	CON	MPLETED		
		245097	B. WING _	·	03	C 03/13/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	1999 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -		
FARIBAL	JLT CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 309	with eating, but did	ge 46 d dated 2/17/14, independent not direct the resident was to safe positioning to eat in bed.	F 30	99		-		
	On 3/11/14 at 9:30 in the wheelchair. the back of the whe the floor, R25's was that his thighs were The wheelchair cus edge of the chair.	a.m. R25 was observed sitting R25's back was not against eelchair, R25's feet were on s sitting forward in the chair so beyond the edge of the chair. whion was beyond the front When asked R25 stated he e sitting in the chair.				1007 1070 1070 1077 1077 1077		
	stated she had just wheelchair and new	a.m. occupation therapist provided R25 with a larger v cushion, but that she had not vheelchair positioning.						
	focus/problem of ne Interventions incluc mobility on the unit almost every time. and ask again kind needs to be reported	ed 2/13/14 identified a eed staff assist with mobility. led use a wheelchair for will refuse to reposition Explain why it has to be done ly. If I am non-compliant it ed to nurse and if nurse cannot osition, report to director of						
	director of nursing expected to follow t would refuse cares the resident. DON had refused to be r							
F 312 SS=D	483.25(a)(3) ADL C DEPENDENT RES	ARE PROVIDED FOR IDENTS	F 31	2				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DAT COM	E SURVEY PLETED
		245097	B. WING				C 13/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	• .	
FARIBAU	JLT CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021			ی ۲۹۱۰ میں ۲۹۱۰ میں ۲۰۱۰ میں
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	daily living receives	nable to carry out activities of the necessary services to	F 3	12			
	and oral hygiene. This REQUIREMEN by: Based on observat review, the facility fa grooming for 1 of 1 required assistance Findings include: R25 lacked persona hair. The quarterly Minim 1/24/14 identified d dementia, depressi	al grooming to remove facial num Data Set (MDS) dated iagnoses of diabetes, on, psychotic disorder. The tal dependence of two staff for			 1.R25 is deceased 2. Director of Nursing/designed complete an audit to identify all residents who are dependent f grooming care. 3. Director of Nursing/designed educated 03/25/2014 all direct care staff on grooming depend residents. 4. Director of Nursing/designe complete weekly random audi ensure staff is providing care f dependent residents. 5. If any issues are identified i be addressed through the faci Quality Assurance meetings. 6. The facility will be in substat compliance by 04/22/2014 	l for e dent e will ts to for t will ility's	4/22/14
	3/10/14 through 3/1 R25 was noted to b 10:25 a.m. R25 was 3/13/14 at 9:30 a.m be unshaven. R25 was interviewe	throughout the survey of 3/14. On 3/11/14 at 9:30 a.m. e unshaven. On 3/12/14 at s noted to be unshaven. On ., R25 was again observed to ed on 3/11/14 at 8:38 a.m. R25 uld only shave him every other aved him this day.				•	
	behavior problems.	ed 2/13/14 identified a focus of Interventions directed if aff should have a nurse Obsolete Event ID:477C11		Fac	sility ID: 00989 If continuatic		Page 48 of 82

PRINTED: 03/31/2014

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· PF		03/31/2014 APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED	
		245097	B. WING				C 13/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	determine the optio	ige 48 on that is least detrimental; ach later if continued to be	F3	312			
	resistive. The care resistive to care wit resist ADLs, reass minutes later and th identified a focus n interventions for gra assist of 1 staff and comb own hair and	plan identified a focus of th interventions that directed if ure, leave and return 5-10 ry again. The care plan eeds assist with ADL's and ooming that directed staff need d encourage participation to					
 	nursing assistant (I aid (TMA)-E stated	v on 3/12/14 at 1:30 p.m. NA)-J and trained medication R25 was last shaved on 5 did not always agree to be					
F 315	3/13/14 at 11:45 a. expect shaving to b and for the care pla resident refused ca re-approach for ca been contacted by be shaved. 483.25(d) NO CAT	sing (DON) was interviewed on m. DON stated she would be included in the care plan an to be followed. If the ares, she would expect staff to res. DON stated she had not staff related to R25 refusing to HETER, PREVENT UTI,	F	315			
SS=D	RESTORE BLADD Based on the resid assessment, the fa resident who enter indwelling catheter resident's clinical c catheterization was who is incontinent	DER lent's comprehensive acility must ensure that a s the facility without an is not catheterized unless the condition demonstrates that s necessary; and a resident of bladder receives appropriate rices to prevent urinary tract					
							Page 49 of 82

Facility ID: 00989

If continuation sheet Page 49 of 82

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		: 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		· · · · · · · · · · · · · · · · · · ·	်င္လ	IPLETED
						С
		245097	B. WING		03	/13/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	ILT CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	ao 19	F 315			
1 515	-	store as much normal bladder				
	by: Based on observa- review the facility fa comprehensive urin and provision of se residents reviewed Findings include: R25 lacked a comp assessment that in lacked provision of the plan of care R25's quarterly Mir 1/24/14 was review diagnoses of deme disorder. The MDS total dependence of living-including toile toileting plan, and w The Urinary and Bo Assessment check R25 had incontiner and impaired mobi functional incontine documented. The Intervention Guidel completed check li functional incontiner assessment for pa	nary incontinence assessment rvices for 2 of 3 (R25, R46)		 F315 1.R25 is deceased, R46 has discharged 2. Director of Nursing/design audit all residents' incontine assessments to ensure they an accurate assessment and provisions of care. 3. Director of Nursing/design provided education 03/25/14 nursing staff on how to compassessments and create provisions of care. 4. Interdisciplinary Team will review resident assessments admission, quarterly, annual with any significant change. 5. If any issues are identified be addressed through the faculatity Assurance meetings. 6. The facility will be in subst compliance by 04/22/2014 	nee will nce have d to olete s upon y and it will cility's	4/22/14

		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				Сом	E SURVEY PLETED
		245097	B. WING	i	· · · · · · · · · · · · · · · · · · ·		C 13/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER				738 HULETT AVENUE NORTH		-
	-			r	ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315		ige 50 Iid not have an analysis of vhy the recommendations	F	315			
	were noted and wh elimination tracking Continence Risk As Continence Intervei identify other contri factors, psychologic	at the outcome of the bladder was. The Urinary and Bowel ssessment and Urinary ntion Guideline Tool did not buting factors such as physical cal factors, behavioral factors, edical diagnoses factors. A developed based on					
	indicated R25 requ toileting and was al analysis of findings resistive to toileting urgency, diabetes, depression as cont identify the type of i	essment (CAA) dated 11/7/13 uired extensive assistance for ways incontinent. The noted R25 was highly . The CAA identified urinary congestive heart failure and ributing factors, but did not incontinence or the voiding The CAA did not provide a on the evaluation.					
	care plan had a foc toileting" and direc hours and per requ	ed 2/13/14 was reviewed. The cus of "staff assist with ted staff offer toileting every 2 est. On 2/13/14 a change was lan that directed a check and					
	observed to be lying soaker pads under to be provided inco On 3/11/14at 11:10	00 p.m., to 7:30 p.m., R25 was g on back in bed. R25 had two him. R25 was not observed ntinence cares for 3.5 hours. a.m., while visiting R25, a vas detected. On 3/11/14 at					
FORM CMS-24	1:30 p.m. R25 was wheelchair. A stron	observed sitting in the g urine odor was detected and pants was observed to be	1	Fa	cliity ID: 00989 If continuati	on sheet	Page 51 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION		E SURVEY PLETED
		245097	B. WING				3/2014
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAUL	T CARE CENTER				1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
v		ge 51 R25 was observed from 10:25 25 was not observed to be	F:	315	5		
ר פ ר ר ר ר	provided incontinen assistant (NA)-J sta and assisted R25 a nours. R25 was ob p.m. to 1:30 p.m. A	tee cares for 3 hours. Nursing ted she had last repositioned t 10:00 a.m. or a total of 3.5 served on 3/12/13 at 12:00 tt 1:30 p.m. R25 received by observation 1.5 hours)					, ,
l v i s a	NA-J stated she ha 10:00 a.m. (a total o vas observed from ncontinence cares she had worked all	d last provided cares to R25 at of 3.5 hours) On 3/13/14 R25 7:09 a.m. to 8:58 a.m. and no were provided. NA-C stated night and had last changed 25 at 5:30 a.m. (greater than					
s. V	stated two soaker p	on 3/12/13 at 1:30 p.m. NA-J bads were under the resident se he "wets a lot and this ugh."			· · · · · · · · · · · · · · · · · · ·		
5 i c t t t t t t t t t t t t t t t t t t	3/13/14 at 11:45 a.r ncontinence asses completed. The as nour bowel and bla exists. The notatio be included on the would expect the ca resident refused ca re-approach for car	sing (DON) was interviewed on m. DON stated the urinary sments were just being sessment was to include a 72 dder diary to see if a pattern ns on the assessments should care plan. DON stated she are plan to be follow. If the res, she would expect staff to res. DON stated she had not staff related to R25 refusing to					
r	receive incontinend	e cares.					
F	olan of care for inco						
	R46 was observed 7(02-99) Previous Versions	on 3/10/14 at 4:10 p.m. A Obsolete Event ID: 477C1	1		Facility ID: 00989 If continuati	on shoet	Page 52 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	TIPLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED C
		245097	B. WING			13/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER	<u></u>		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(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 315	Continued From pa strong urine smell v	ge 52 vas noted. Licensed practical d he also noticed the odor but	F 3	15		
	was unsure if the or resident. LPN-I stat cleaned up. No stat incontinence or odd at 10:05 a.m. and a observed sitting by members present. noted. No staff inter incontinence and or 3/13/14 at 7:10 a.m.	dor was from R46 or another ed R46 did not like to get ff interventions related to the or was observed. On 3/12/14 t 10:25 a.m. R46 was the nursing station with 3 staff A strong urine smell was rventions related to dor were observed. On . a strong urine odor was observed to be wearing the				
	nursing assistant (N odor, when near F4 get a shower twice observed to interve R46 was admitted Summary dated 11,	on 3/13/14 at 7:50 a.m. NA)-C verified a strong urine 6. NA-C stated R46 was to a week. NA-C was not ne. 11/5/13. The Care Conference /25/13 identified diagnoses of rsisting dementia, bipolar				
	11/12/13 and the qu both identified R46 interview for menta	natic brain injury. imum Data Set (MDS) dated uarterly MDS dated 1-12-14 as having a BIMS score (brief I status) of 13 or no cognitive always be continent.				
	December docume every other day due documented the re- was not given the c Conference Summ	rd for November and nted R46 was to get a shower to incontinence but sident frequently refused or opportunity. The Care ary dated 11/25/13 noted te [sp] in pants and refuse to		Equility ID: 00089.		Page 52 of 82

Facility ID: 00989

If continuation sheet Page 53 of 82

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DAT CON	. 0938-0391 E SURVEY MPLETED C
		245097	B. WING		03,	/13/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 315	Continued From pa change."	ge 53	F 31	5		
	Bowel Continence checklist identified without documenta that a physician exi- identified nocturia, demonstrated char incontinence and c bladder/urge incom- not identify other co- physical factors, ps factors, medication factors. The asses of care based on th	cy completed Urinary and Risk Assessment. The impaired bladder emptying tion of a post void residual or am had been completed, and determined the resident acteristics of overflow haracteristics of over active tinence. The assessment did portributing factors such as ychological factors, behavioral s and medical diagnoses asments did not provide a plan he evaluation. No CAA was or urinary incontinence.			· · ·	
1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1 1.1.1.1.1 1.	reveal a plan/interv manage incontiner the resident as inde living. The care pla	plan dated 2/18/14 did not entions to assist R46 to ice. The care plan identified ependent with activities of daily an also directed if the resident director of nursing was to be				یند کر ۱۹۹۵ - ۲۰۰۹ ۲۹۹۵ - ۲۰۱۹ ۲۹۹۵ - ۲۰۱۹ ۲۹۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ - ۲۰۹۹ ۲۹۹۹ - ۲۹۹۹
F 323	3/13/14 at 11:45 a. incontinence asses completed. The as hour bowel and bla exists. DON state refusal of cares. 483.25(h) FREE O	sing (DON) was interviewed on m. DON stated the urinary sements were just being sessment was to include a 72 adder diary to see if a pattern of she had not been notified of F ACCIDENT	F 32	23		
SS=D	The facility must e	nsure that the resident ins as free of accident hazards				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				D: 03/31/2014 MAPPROVED
		& MEDICAID SERVICES			OMB NO	0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' <i>'</i>	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245097	B. WING		- 03	C 3/13/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		
	JLT CARE CENTER			1738 HULETT AVENUE NOF FARIBAULT, MN 55021	RTH	
			1		N OF CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	E ACTION SHOULD BE D TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE
F 323	Continued From pa	ae 54	F	323		
	as is possible; and	each resident receives on and assistance devices to				
	prevent accidents.				· · · · · · · · · · · · · · · · · · ·	
r an an An An an An				F323 1.R40 falls trend completed, R70 h	nas been	
	by: Based on interviev facility failed to tho comprehensively a develop interventio	NT is not met as evidenced v and document review, the roughly investigate, ssess, effectively analyze and ns to minimize risk of falls for 40, R70) reviewed for		discharged to AL 2. Administrator/o fall in last 30 days proper investigati completed 3. Administrator/o educated 03/25/1 policy and proceo	designee will audit s to ensure a ion has been designee l4 staff on the	
	resident was admit with diagnoses whi fall, intracerebral h	ras reviewed and identified the ted to the facility on 1/11/2014 ch included personal history of emorrhage, obstructive hizoaffective disorder, paralysis ression of brain.		completing fall in	vestigation designee will take ly meeting with eam for a fall o ensure falls rly investigated	
- 	Set, dated 1/17/20 moderate cognitive total assist of 1-2 s The resident had a Accident/incident re	eports for R40 were reviewed.		5. If any issues at be addressed thr Quality Assuranc 6. The facility will compliance by 04	ough the facility's e meetings <i>.</i> be in substantial	4/22/14
	On 2/15/2014, the the bed, had attem no injury. Residen confused, impaire	resident was on floor next to pted to self-transfer and had t was identified as being d decision making, weakness,				
	The resident had b	I having impaired memory. een ambulating without se of medications had not been s Obsolete Event ID:477C1		Facility ID: 00989	If continuation shee	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2014 \PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		(X3) DATE COMF	SURVEY PLETED
		245097	B. WING			03/1	, 3/2014
NAME OF F	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP COI	DE	
FARIBAL	JLT CARE CENTER			1738 HULETT / FARIBAULT,	AVENUE NORTH MN 55021		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	DVIDER'S PLAN OF CORR I CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323		was no evidence of an	F3	323			
	implemented. The reports dated 2/21/ were not thoroughly	incident or interventions resident had subsequent 2014 and 2/22/2014 which / investigated to include review t could predispose the					
	admission) was rev resident with 3 or m resident's cognitive perception or aware was confined to wh physical support. F	ent dated 1/11/2014 (on riewed. It identified the nore falls in the last 90 days, status had periods of altered eness of surroundings, mobility eelchair and always needing 840 had a neuromuscular or e assessment indicated the igher risk for falls.					
in dia manggan kana kana kana kana kana kana kan	R40's care plan up date of 1/14/2014 v falls risk and interv falls. A written note of 2/15/2014) ident for falls due to mult impaired balance, o unsteady gait. Inte within reach, bed a	on admission with initiated vas reviewed. It did not identify entions to minimize the risk of a dated 2/19/2014 (after the fall ified the following: I am at risk iple risk factors, related to decreased endurance and rventions: OT/PT, call light nd chair alarm, appropriate roll brakes on wheelchair.					
	director of nursing verified the medica time of the fall to de incident report was thorough investigat identify causes and DON stated a fall th completed for the f On 3/13/2014 at 12	2:50 p.m., the director of					
FORM CMS-2	567(02-99) Previous Versions	ewed. She stated R40's care S Obsolete Event ID:477C1	1	Facility ID: 00989	lf co	ntinuation sheet I	Page 56 of 82

Facility ID: 00989

		AND HUMAN SERVICES			0	FORM A	03/31/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	LETED
		245097	B. WING			-	3/2014
	PROVIDER OR SUPPLIER			17:	REET ADDRESS, CITY, STATE, ZIP CODE 38 HULETT AVENUE NORTH ARIBAULT, MN 55021		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa plan (on admission _with interventions_s of falls.	ige 56) should have addressed falls ince the resident had a history	F:	323			
	bedroom on 3/5/14 fallen in room, "bur stand." Observation and redness to righ signs taken, sent to and R70 refused no R70 experienced a bedroom on 3/6/14 his room. BP 126/7 head. R70 experienced a bedroom on 3/9/14	second unwitnessed fall in his at 6:45 p.m.stating he fell in 8 pulse 89 and denied hitting third unwitnessed fall in his at 11:07 a.m. stating slipped th cheek and shoulder on the					
	necessary (prn) me (milligram) to be ta According to the M requested a prn do and 3/8. According Handbook, Trazad system adverse re dizziness, syncope	an order for the whenever edication Trazadone 50 mg ken at bedtime for depression. arch medication sheet, R70 use of Trazadone on 3/4, 3/5, to the Nursing 2014 Drug one has a central nervous actions of drowsiness, (fainting) and for re could be adverse reactions					
	Set (MDS) form da limited to, hyperte weakness. The MI falls with fracture 2	osis from the minimum Data tted 1/16/14, lists but is not nsion, anxiety and muscle DS further indicated a history of 2-6 months prior to admission. we for Mental Status (BIMS)					

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

PRINTED: 03/31/2014 FORM APPROVED

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245097	B. WING		03	/13/2014
	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 1738 HULETT AVENUE NORT FARIBAULT, MN 55021	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
da		cated a summary score of 14	F 32:	3		
W di fo ac In pr in m	/hen interviewed of rector of nursing (r R70 did not add elp prevent future ctivity R70 experie formation was no recipitating factors cluding depressio	on 3/12/14, at 11:30 a.m. the DON) verified the three falls ress any precipitating event to falls which included the enced prior to the fall. t available related to the associated with the resident, n/blood pressure/pain I observation of anxiety level				
Pi Tr th lis th F 329 48	rogram" directed t rend Investigation e section to identi st the prn medicati e past 24 hours.	nent titled "Fall Prevention he DON to complete a "Fall Report" which was blank in fy medication profiles and to ons the resident received in EGIMEN IS FREE FROM RUGS	F 329	9		
ur dr dı wi in ac sh	nnecessary drugs ug when used in uplicate therapy); ithout adequate m dications for its us dverse consequen	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any e reasons above.				
re wl	sident, the facility ho have not used	hensive assessment of a must ensure that residents antipsychotic drugs are not mless antipsychotic drug				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPRO //B NO. 0938-0	VED
STATEMENT OF D AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
		245097	B. WING _		C 03/13/2014	4
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAULT (CARE CENTER			1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(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 APPROPF DEFICIENCY)	BE COMPLÉ	TION
the as	diagnosed and c	y to treat a specific condition locumented in the clinical	F 3:			
rec dru beł cor dru Fin by: Ba fac faile psy (R2 me Fin R2: par effe nor mu with R2 (fro am deg dia typ dis	ord; and residen gs receive gradu navioral intervent itraindicated, in a gs. s REQUIREMEN used on interview ility failed to deve ed to monitor the ccho-active medi 27, R40) reviewe dications. dings include: 7 was on an anti ameters for use ectiveness when n-pharmacologic litiple scheduled hout adequate m 7 was admitted to m care plan) alt putation of toes, betes, hypertens e dependence a order, drug-induce	ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these NT is not met as evidenced <i>y</i> , and document review, the elop parameters for use and e effectiveness of as needed cations for 2 of 5 residents of for unnecessary -anxiety medication without , documentation of used, and without use of al interventions; and was on psychotropic medications		 F329 1.R27 parameters has been implemented, care plan has been updated to reflect non-pharmacological interventions a target behaviors have been identified. R40 parameters has been implemented, care plan has been updated to reflect non-pharmacological interventions, sleep assessment also complete 2. The DON/designee will audit a resident currently taking prophylactic antibiotic medication to ensure clinical rationale is present. The DON/designee will review all residents taking psychractive medications to ensure parameters and effectiveness has been monitored. 3. The DON/designee educated 03/25/14 nursing staff on the importance of prophylactic antibiotic medications to have clinical rationale. The DON/designee will educate nursing staff on psychotropic medication and behavior monitoring policy and procedure. 	ind as ed. all n	

Facility ID: 00989

If continuation sheet Page 59 of 82

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NC	/I APPROVED <u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245097	B. WING			8/13/2014
	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021	E	
(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 SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329		ge 59 ated 2/3/2014 identified R27 5 mg twice daily as needed for	F 32	F329 Continued		
	severe anxiety. Th psychoactive medic Zyprexa, and Trilafo Medication sheets of reviewed. The resis clonazepam (antiar times in both month psychotropic medic The target behavior monitored included indicators, hearing objects not there, a direction, and paci documented on ever analysis of the behavior data to identify effe needed antianxiety	e other scheduled cations were Buspar, Elavil,		4. The DON/designee will new prophylactic antibiotic medications 3 times a weel the nursing management compliance rounds to ensu clinical rationale is present. DON/designee will monitor psycho-active medications per week to ensure parame and effectiveness are being monitored using the nursin management compliance r 5. If any issues are identified be addressed through the Quality Assurance meeting 6. The facility will be in sub compliance by 04/22/2014	k using re The 3 times eters g g ounds. ed it will facility's gs. ostantial	4/22/14
	of 2/20/2014 was re necessary and sch	iated 2/5/2014 and print date eviewed. The use of the as eduled psychotropic terventions was not				
	interviewed regardi medication. DON s documenting in the effectiveness. The pharmacological in	2:50 p.m., the DON was ng use of prn antianxiety stated staff should be MAR and follow up for y are to attempt non terventions prior to the prn				
		tation was not evident in the the DON verified that.				

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Facility ID: 00989

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If continuation sheet Page 60 of 82

		AND HUMAN SERVICES				FORM	: 03/31/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED C
		245097	B. WING			03/	13/2014
	PROVIDER OR SUPPLIER			17	REET ADDRESS, CITY, STATE, ZIP COD 738 HULETT AVENUE NORTH ARIBAULT, MN 55021	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa On 3/13/2014 at 12 DON was interview	2:50 p.m., and 3:00 p.m., the	FS	329			
	summary/analysis identify effectivene and use of the as n She indicated no a	of the behavioral data to as of the scheduled medication needed antianxiety medication. nalysis was done of the o criteria for the use of the as			· · · · · · · · · · · · · · · · · · ·		
	sleep and anxiety w monitoring of effect	ed antianxiety medication for vithout criteria for use, tiveness and lack of use of cal interventions prior to					
	1/9/2014 identified	ary from the hospital dated R40 used as needed iety and every bedtime for					
	schizoactive disorc compression of bra alcohol use, intrace	4 with diagnoses hx of falls, ler,paralysis agitans, ain, parkinson's disease, hx of erebral hemmorrhage, ephalus, insomnia. (on MD					
	Lorazepam 0.5 mg needed for anxiety	lated 1/16/2014 identified by mouth every 6 hours as ; and Lorazepam 0.5 mg (4 nouth at bedtime as needed for					
	Lorazepam (antian necessary for sleep	adication sheets were reviewed: xiety medication) was used as p and/or anxiety: 1/149 sed 23 times and in 3/14-it s Obsolete Event ID:477C1	-	Fac	sility ID: 00989 If cor	ntinuation shee	Page 61 of 92

Facility ID: 00989

		AND HUMAN SERVICES					FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ISTRUCTION		COM	E SURVEY PLETED
		245097	B. WING				03/1	3/2014
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ULETT AVENUE NORTH			•
FARIBAU	JLT CARE CENTER				AULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 329	Continued From pa was used 8 times.	age 61	F 3	329				
	reviewed. It identifie staying asleep; rela history of taking sle to bedtime. An ave hours. R40 had ne Parkinson's diseas environmental facto sleeping difficulties assessment was a contain a summary determine a plan. R40's care plan wit and print out date of	dated 1/13/2014 was ed the resident had difficulty ated to pain; did not have a eep medications routinely prior rage length of nap was 1-2 eurological deficits (stroke, e, seizure disorder). No fors contributing to resident was identified. The collection of data but did not or analysis of the data to h initiated date of 1/14/2014 of 2/20/2014 was reviewed. It 0's sleep issues or use of as medications with						
	assistant (TMA)-C of the antianxiety m she did not give the and indicated R40 night for sleep. The rarely used it throug resident was up an know if there was c medication.	:45 a.m., a trained medical was interviewed regarding use nedication. TMA-C indicated e medication during the day was given the medication at e resident got anxious but ghout the day because the d about. The TMA did not rriteria to use prior to giving the						
	DON was interview antianxiety medicat be using non pharm	2:50 p.m. and 1:05 p.m., the red regarding criteria for use of tion. DON stated they should nacological interventions prior			0000			
FORM CMS-2	567(02-99) Previous Versions	S Obsolete Event ID:477C1	1	Facility ID:	00989	ii continuati	on sneet H	Page 62 of 82

		AND HUMAN SERVICES		·			FORM	03/31/2014 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Y	TIPLE CONS		_	COM	E SURVEY PLETED
		245097	B. WING			_	C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, ST			n
FARIBAU	JLT CARE CENTER				ETT AVENUE NO ULT, MN 55021			·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIN ROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD D TO THE APPROPR ICIENCY)	BE	(X5) COMPLETION DATE
F 329		ge 62 medication and should be r effectiveness. The DON	F3	329				4 ty - 4 4
F 367 SS=D	indicated she just d 2/17/2014. She als monitoring and indi DON verified they c assessment data to	id an education on that on to checked for R40 re: sleep cated it was not being done. did not analyze the sleep to come up with a plan. TEUTIC DIET PRESCRIBED	F 3					
	Therapeutic diets n attending physician	nust be prescribed by the			were address	for thickened fl ed with PCP bleted of all resi		
	by: Based on observat review the facility fa thickened liquids as	NT is not met as evidenced tion, interview and document tiled to ensure the provision of s ordered by the physician for a) reviewed with thickened			ensure all die 3. Staff educa where to find by DON/Desig 4. IDT will rev	by DON/desig t orders are acc ated on 03/25/1- resident diet or gnee view dietary ord- uarterly, annual	curate 4 ders ers on	
terre generalista nationalista nationalista	Findings include: R29 was not provid meals.	ed thickened liquids during			with any signi 5. If any issue be addressed	ficant change. es are identified through the fac ance meetings.	it will cility's	
	R29 was admitted t diagnoses that inclu	o the facility in 2011 and had uded diabetes, Alzheimer's, ing to the physician orders	-			will be in subst		4/22/14
	eating lunch indepe served a regular die tray were a glass of cup of tea. At 12:3	on 3/12/14 at 12:20 p.m. endently. R29 had been et with regular liquids. On the water, a glass of juice and a 0 p.m. trained medication aide poon into each glass and						

1.75

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		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	CON	TE SURVEY MPLETED
		245097	B. WING			/13/2014
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COL	DE	
FARIBAL	JLT CARE CENTER			738 HULETT AVENUE NORTH FARIBAULT, MN 55021		· · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 367	stated she had not	ge 63 are of thin consistency. TMA-E observed R29 to cough while aserved during the morning	F 367			
e	meal on 3/13/14 at regular diet and thin juice, milk, water.) thin. Nursing assis	8:15 a.m. R29 was served a n liquids (orange juice, prune TMA-F stated the liquids were tant (NA)-C stated R29 had				
	started working in t verified on the med	d liquids since NA-C had he facility a year ago. TMA-F lication administration record to be nectar thick and hickener.				
	12/31/13, 2/5/14, 3 ADA/mechanical so for thin milk on cerv therapist recomme tray card on the me was to receive nec	rs dated 10/26/13, 11/27/13, /12/14 all ordered Liberal off with nectar thick liquids. Ok eal. On 2/12/13 the speech nded nectar thick liquids. The eal tray identified the resident tar thick liquids. The care area dated 8/5/13 did not identify as to receive.				. (
	1/13/14 indicated F assist of one staff, was on a therapeu speech therapy. T	num Data Set (MDS) dated R29 was able to eat with limited had no swallowing disorder, tic diet, and did not have he dietitian notes of 3/12/14 receive a liberal ADA diet with				
	initiated 6/7/11 and stated R29 had a s difficulty with regula during meals or sw Interventions dated followed as prescri	plan identified a problem revised on 10/11/13 that wallowing problem related to ar food. Coughing or choking vallowing medication. 4 /20/13 indicated diet to be bed: liberal diabetic, xtures with thin liquids.		acility ID: 00989	ntinuation shoo	t Page 64 of 82

		AND HUMAN SERVICES			I	FORM	03/31/2014 APPROVED 0938-0391
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION (>	(X3) DATE SURVEY COMPLETED C	
		245097	B. WING	i	<u> </u>		3/2014
NAME OF F	PROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From pa	ge 64	F	367			
•	During an interview	on 3/13/14 at 8:33 a.m. the					
	administrator stated were to be thickened an interview on 3/13 stated she was una thickened liquid unt note from licensed	d she was aware the liquids ed and had not been. During 3/14 at 1:00 p.m. cook-C ware of the need for the il today when she received a practical nurse (LPN)-J that					
	the diet order was o	changed to thin liquids.					1120 - 4 11-22 pile - 1
	stated that since las	wed 3/14/14 at 1:10 p.m. and st August when LPN-J started ty, R29 had not received					
F 371 SS=E	483.35(i) FOOD PF STORE/PREPARE The facility must -	ROCURE, /SERVE - SANITARY	F	371	F371 1.Education of Dietary staff to encompass sanitation of kitcher	n by	
	(1) Procure food fro considered satisfac authorities; and	om sources approved or story by Federal, State or local			2. Audit completed of Dietary Department to determine if there	a ie	стана н
	(2) Store, prepare, under sanitary conc	distribute and serve food ditions			any sanitation concerns identifie by Dietary Consultant. 3. Dietary staff educated by	ed	n a tradición de set Ser esta de set Ser esta de set
					dietician on maintaining a sanita dietary department.		
с. 1911	by: Based on observat	NT is not met as evidenced tion, interview, and document			 Dietary Manager will complete weekly audits of dietary department to be reviewed with Administrator weekly. 	9	
	environment in the storage and prepar potential to affect 4	ailed to ensure a sanitary ktichen was maintained for ation of food. This had the 1 of 43 residents in the facility			5.If any issues are identified it wi be addressed through the facility Quality Assurance meetings.	ll 's	
$\frac{1}{T} \frac{1}{m_{2}} \frac{1}{m_{1}}$		en foods prepared from this			6. The facility will be in substanti compliance by 04/22/2014	al	4/22/14

Facility ID: 00989

If continuation sheet Page: 65 of 82

		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY IPLETED
		245097	B. WING	. <u></u>			13/2014
	PROVIDER OR SUPPLIER	L		17	REET ADDRESS, CITY, STATE, ZIP (38 HULETT AVENUE NORTH	CODE	
			10		PROVIDER'S PLAN OF CO	BRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE
F 371	Continued From pa Findings include:	age 65	F	371			
	kitchen was comple	45 p.m., an initial tour of the eted with Cook-A and Cook-B. observed during the tour:	· · · · · · · · · · · · · · · · · · ·				-
	on a soiled metal s All three shelves of food equipment sto debri. A hand mixe The cupboards whi	obot Coupe Blixer 3, located tand, were coated with debri. the cart on wheels, which had ored, were soiled with food r was coated with food debri. ich had the spices stored were ood debri and also inside the bod utensils stored.					
	sauce and mayona containers that wer However, they wer	tor was a tray of barbecue lise in small individual plastic re covered with a clear wrap. e dated 3/2/14. The cook bods are used within 3 days.					
	shelving that conta On 3/12/2014 at 12 were laying on the	aff purse were stored on the ined several loaves of bread. 2:30 p.m., a case and book same shelf as the bread racks. vas employee items and				۰ ۱ ۱	
	very thick limed en double boilers were encrusted with thic boilers were pitted were used to make large skillet was ob blackened. The co new one and was of facility to use for m	ment steam table was full of crusted material. Two large e observed. The bottoms were k lime. The tops of the double and dented. Cook-A said they e soups and noodles. A very oserved to be pitted and ook indicated she asked for a given a skillet from a sister taking eggs, and other					
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 477C1	1	Fac	sility ID: 00989	continuation sheet	Page 66 of 82

		AND HUMAN SERVICES					FORM /	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(CONSTRUCTION		(X3) DATE COMF	PLETED
		245097	B. WING					3/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, Z	IP CODE		
FARIBAL	JLT CARE CENTER				38 HULETT AVENUE NORTH ARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULE THE APPROP	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 66	F3	371				
	The ice machine ha	ad a layer of food debris along						
	were resident use were resident use were resident to cart located next to cracked and discological contents of the content o	lid where it opened. There water cups stored in a closed the ice machine that were ored on the inside of the cups. he thought night staff ran the ishwasher nightly.						
	On 3/12/2014 at 11 kitchen was made:	:45 a.m. observation of the	-					
	laying on the same	ersonal reading book were shelf as the bread loaves. e employees items shouldn't be						ار قفری ا فرو ما با در آر
i i Sana an i Sana an i Sana an i	with Cook-B for the Several tasks were and Cook-B said th off and there are tin	ule for cleaning was reviewed e month of March 2014. e not checked as being done ney sometimes forget to mark it mes they just don't have time done because there is so						
	concerns noted in	2:30 p.m., Cook B verified the						
	a.m., with the direct director of houseke located in the dinin secured unit was c	mental tour on 3/13/14 at 8:30 stor of maintenance and eeping the resident refrigerator of room/day room on the shecked. The upright						
	refrigerator freezer cream and other fo and floor of the fre	r compartment had melted ice bod debri spilled on the walls ezer. The refrigerator several resident labeled			ility ID: 00989			Page 67 of 82

		AND HUMAN SERVICES				FORM	: 03/31/2014 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245097	B. WING				C 13/2014
NAME OF	PROVIDER OR SUPPLIER	L		SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBA	ULT CARE CENTER		-		738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	bread crusts were of	ere not fully sealed and the dry to touch. The two pull out	F3	371			
	drawers located at compartment were there was visible bl housekeeping supe Interview with the n	the bottom of the refrigerator soiled with food spills and ack/brown debris the ervisor thought was mold. naintanance director, it was ator is to be cleaned by the					
F 406 SS=D	dietary staff. 483.45(a) PROVID REHAB SERVICES If specialized rehab	E/OBTAIN SPECIALIZED	F۷	406	F406 1.R46 was discharged from fac 2. SSD educated 04/17/2014	ility	
	pathology, occupat health rehabilitative and mental retarda resident's compreh must provide the re required services fr accordance with §4	ional therapy, and mental e services for mental illness tion, are required in the ensive plan of care, the facility equired services; or obtain the rom an outside resource (in 83.75(h) of this part) from a zed rehabilitative services.			 2. 33D educated 04/17/2014 regarding residents admitted wisignificant alcohol/drug abuse history, that assessments need be completed and referrals mac as appropriate. 3. Admin/SSD will complete reviews of admissions regarding potential need for in-pt/out-pt 	to le	
10 • • • * 10	by: Based on interview facility failed to prov necessary for 1 of Findings include:	NT is not met as evidenced v and document review the vide rehabilitative services as 1 resident (R46) reviewed.			 rehab services 4. Daily meeting will encompass review of potential admissions a needs including discharge planning. 5. If any issues are identified it w be addressed through the facility 	nd /ill	
	R46 was admitted of hospital to the facili R46's diagnoses lis	al for rehabilitation services. on 11/5/13 from an acute care ty's locked dementia unit. ted on the preadmission /5/13 at Karsakoff dementia	•		QA meetings. 6. The facility will be in substanti compliance by 04/22/2014	al	4/22/14

Facility ID: 00989

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		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245097	B. WING	· · · · · · · · · · · · · · · · · · ·		/13/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
FARIBA	ULT CARE CENTER	c		1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 406	(alcohol induced de The care plan printe	mentia) and bipolar disease. ed 2/18/14 identified R46's	F4	06		
		ol induced dementia, bipolar pendence, drunkenness, atitis.				
undan Kangar	11/12/13 and the qu indicated R46 had a status (BIMS) score impairment, display	imum Data Set (MDS) dated arterly MDS dated 1/12/14 a brief interview for mental of 13/15 or no cognitive ed no behaviors, was ctivities of independent living.			• • •	
	stated was admitted abuse and had not program. R46 state outpatient services, community, but hac	on 3/10/14 at 5:13 p.m. R46 d with a diagnosis of alcohol been involved in a treatment ed he had investigated found some available in this I not been provided access to he would be willing to do ent treatment.				
	noted, "Resident w facility or a facility w The care plan printe	e summary dated 11/25/13 ould like to be in a treatment here people are younger." ed 2/18/14 was reviewed. The th alcohol and request for noted.				
	director of nursing (on 3/13/14 at 12:10 p.m. the DON) stated she thought working on the treatment				
	interviewed on 3/13 R46 had discussed treatment as outpat	designee (SSD) was /14 at 12:57 p.m. SSD stated with her the request of ient or inpatient. SSD stated the guardian. SSD stated the	λ			

PRINTED: 03/31/2014

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		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED	
STATEMENT	S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CTION	(X3) DAT CON	0938-0391 E SURVEY IPLETED	
		245097	B. WING			C 03/13/2014		
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>			ESS, CITY, STATE, ZIP CC			
FARIBAU	JLT CARE CENTER			FARIBAULT				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	ROVIDER'S PLAN OF CORI CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 406	because guardian v	ant R46 to go to treatment was afraid R46 would not be	F4	406				
	able to return to the she had also discus case manager and needed to get the g the management te not hold the bed for inpatient treatment if a readmission be	e nursing home. SSD stated ssed treatment with the county that he had said the facility guardian on board. SSD stated eam stated the facility would r return following the 90-day program so SSD did not know d would be available. SSD						
F 441 SS=E	outpatient treatmer to find any social se previous social wor programs.	investigated further for nt. SSD stated she was unable ervices documentation from ker related to treatment N CONTROL, PREVENT	F 4	441				
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				x • • • •		
	Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t	stablish an Infection Control ich it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective						
	determines that a r	ead of Infection tion Control Program esident needs isolation to of infection, the facility must						
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID:477C11		Facility ID: 00989	If co	ontinuation sheet	Page 70 of 82	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/31/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245097	B. WING	i			13/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		· · ·
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	isolate the resident. (2) The facility mus	prohibit employees with a	F۷	441		-	
	communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must har transport linens so a infection. This REQUIREMEN by: Based on observat review, the facility fa to prevent the sprea change for 1of 2 res tube dressing and ti isolation precaution residents (R48) with failed to assure 1 of equipment was san Findings include: R45 had a gastric fe dressing change, in	ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their rect resident contact for which licated by accepted e. adle, store, process and as to prevent the spread of IT is not met as evidenced ion, interview, and document ailed to implement procedures ad of infection during dressing sidents (R45) with a gastric ube feeding, failed to ensure s were adhered to for 1 of 1 n isolation precautions and 1 residents (R10)Nebulizer			 F441 1.Nursing staff educated 03/25/2014 by DON regarding infection control practices related to dressing changes, neb treatments, tube feedings and isolation precautions. 2. Nursing staff educated by DON/Designee 03/25/2014 related to dressing changes, neb treatment, tube feedings, and isolation precautions. 3. Infection Control audits will be completed weekly by DON/Designee to ensure the facility is preventing the spread of infection. 4. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 5. The facility will be in substantial compliance by 04/22/2014 	ed I	4/22/14
	diagnoses (listed fro	l on 12/26/2013 with om the care plan) that lopathy, dysphagia, history of	2			τ	

Event ID: 477C11

Facility ID: 00989

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		AND HUMAN SERVICES					FORMA	03/31/2014 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /		NSTRUCTION	0	(X3) DATE	0938-0391 SURVEY PLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	DING		-	C	
		245097	B. WING					, 3/2014
NAME OF I	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STA			
FARIBAL	JLT CARE CENTER				IULETT AVENUE NO BAULT, MN 55021	RIH		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	I	PROVIDER'S PLA	N OF CORRECTIO		(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIV CROSS-REFERENCED DEFI			DATE
					e en la constante de la constan L			· · · ·
F 441	Continued From pa		F 4	441				
	traumatic brain inju	ry, post traumatic seizures, avioral disturbances, episodic						••••••
	mood disorder, sch	nizophrenia, and CVA (stroke).				<u>.</u>		2011.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0
	During observation	s, on 3/11/2014 at 9:20 a.m., 45's room to do a dressing						
		gastric tube. LPN-C gloved						
1999 - Alexandre I.	and removed the d	ressing which had a tiny bit of						
	blood tinged draina	ge on it. Without changing						
•	gloves, the LPN op	ened drawers and touched , the resident's chair, door						
		et, a blood pressure cuff, bag						
	containing oral tool	thettes, and a mat which was						
	leaning against the	closet. Keeping the same						
	gloves on, the LPN	I took water from a pitcher and n around the gastric tube						1
1.44	stoma area Sligh	t pinkish drainage was noted						2000 - C.
	on the Q-tip. LPN-0	C then touched the medication						
	and feeding syring	e and tube extension. LPN-C						
	snapped the exten	sion on the gastric tube and cy using a stethoscope. When						
	attempting to admi	nister water, the water did not						
	go in. LPN-C had	to use the stethoscope again			•			
	to listen for patenc	y. At that point, the LPN-C was						
	wearing the same	soiled gloves and touched the stethoscope and the tubing.	-					
	She disconnected	the extension tube and took it						
	into the bathroom t	to rinse it out. The LPN -C did						
		led gloves and continued to						
		ion tube to the gastric tube. the soiled gloves, the LPN-C						
	continued to admir	hister water and medication						
	through the tube us	sing the same syringe. After						
	LPN-C was finishe	d with the medication task, she						
	did not have gauze	e to put around the stoma area. soiled gloves and went out to						·
	the medication car	t to find the gauze. The LPN			-			
	gloved and put the	gauze around the stoma.						
FORM CMS-2	2567(02-99) Previous Version	s Obsolete Event ID: 477C1	1	Facility II	D: 00989	If continua	tion sheet F	Page 72 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 03/31/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CO		ATE SURVEY DMPLETED	
		245097	B. WING			0	3/13/2014
NAME OF F	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE,	ZIP CODE	
FARIBAL	JLT CARE CENTER				IULETT AVENUE NORTH BAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 72	F۷	441			
	nursing (DON) was infection control pro dressing change to DON stated the nur standard precaution for dressing change	00 a.m., the director of interviewed regarding lack of ocedures used with R45's the gastric tube site. The rse's should be following and also the facility policy es that are not sterile. A policy provided by the facility.					
	revised 6/2013 was Place supplies on of Apply clean gloves, and dispose of in b hands. 12. Apply cl per physician order to outer boarders u most contamination do not touch other bedding, etc., and r contaminate the wo cleaning supplies in	g-Non-sterile Treatment reviewed. It identified: "6. lean field. 7. Wash hands. 8. 11. Remove soiled dressing ag. Remove gloves. Wash ean gloves. 13. Clean wound s. Cleanse wound from center sing a circular motion (area of to area of least). Ensure you skin surfaces, furniture, eturn to wound bed as this will bund bed. 14. Dispose of to bag. 15. Remove gloves and pply clean gloves. 17. Apply d."					
	aureous (MRSA) w infection control pre implemented. A physician note da of present illness: chronic tracheostor shortness of breath MRSA and Pseudo	y methicillin resistant staph yith a tracheostomy and ecautions were not consistently ated 3/5/2014 identified history Respiratory: Patient with ny and with increased cough and sputum culture showed monas and started on IV ent for bronchopneumonia:			•		
	667(02-99) Previous Versions	ent for bronchopneumonia: Obsolete Event ID:477C1		Eagility II): 00989	If continuation shee	

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			CON	E SURVEY IPLETED
*		245097	B. WING	i			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	I	A	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	Continued From pa possible pneumoni pseudomonas and	a with sputum with	F 4	441			
	closed. A note to c the wall at the door	20 p.m. R48's room door was heck at nurse's station was on way. A plastic cupboard at the gowns, gloves, masks, red pressure cuff and					
	ambulating in the h mask over a trach s medication cart wai a.m., R48 was obse with the mask off th practical nurse (LP trach site and tells because of an infec stated the resident	00 a.m. R48 was observed all with a walker and had a site and then stood at the ting for medications. At 9:00 erved to come out of the room he trach site. A licensed N)-C puts a mask over the the resident it needed to be on ction the resident had. LPN-C was on precautions related to lin resistant staph aureos					
	(mrsa). LPN-C glo stated she didn't go didn't spit. She wo in the air and cough was not good abou LPN went into the r resident out of the h the mask off the tra	ved and put a mask on and own because the resident re a mask because of droplets ning from the trach and R48 t leaving a mask on. The esident room and assisted the pathroom. The resident took uch and sat on the edge of the					
· · · · · · · · · · · · · · · · · · ·	with a mask over th medication cart. Th walker to redirect th and then without cle to set up medication removed the mask basket on the cart b	R48 came out of the room he trach and stands by the he LPN touched the resident's he resident away from the cart eansing her hands continued hs. At 10:00 a.m., R48 and threw it on top of a waste but it just laid on top of the blied a new mask and				· · ·	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/31/2014 1 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>'</i>		CONSTRUCTION		TE SURVEY MPLETED .
		245097	B. WING	-			/13/2014
	PROVIDER OR SUPPLIER			17	REET ADDRESS, CITY, STATE, ZIP C 38 HULETT AVENUE NORTH ARIBAULT, MN 55021	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
. F 441	Continued From pa continued to set up washing her hands	the medication without	F	441			
	At 2:05 p, R48 ca to nurse's desk with The resident's roon hall and so the resi	me ambulating out from room nout a mask over the trach. In is the second door down the dent walks a distance to get to The nurse saw the resident					
	nursing station and	:00 a.m., R48 walked into the stood over NA-K who tried to at back to his room since the not covered.					
	with walker at nurse on trach site. At 9: ambulating in the h mask on. LPN-C to touched the walker medication, withour	45 a.m., R48 was observed up e's desk, however, had a mask 45 a.m., R48 was observed hallway with walker and no ried to redirect the resident, r, and continued to set up t washing hands, while the					
	wear a gown in the gloves because the and she didn't ever everything goes up there. At 10:00 a.r with mask and glov	e. LPN-C indicated she didn't room but just a mask and resident didn't cough or spray during suctioning because the tube and there is no spray n., LPN-C entered the room ves on. There were no gowns tside the room. The resident is				• • •	
	already laying in be incontinent cloth pa the resident 's feet the resident's foreh she raised the bed changing gloves, L	ed. The LPN pulled on the ad under the resident, moved t, touched the linens and then nead. With her gloves still on, with the controls. Without .PN-C removed the mask over					
	the trach, and then and disposed of it i	n, touched the dressing around removed the inner cannula in the wastebasket. Then d gloves (had mucous on them) s Obsolete Event ID:477C1			sility ID: 00989 If	continuation shee	

		AND HUMAN SERVICES				FORM	: 03/31/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /		E CONSTRUCTION	Сом	E SURVEY IPLETED C
		245097	B. WING	i			13/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441		LPN Opened up the new	F	441			
	package of cannula With the gloves still neb medication into and started it up an over the trach. She and dated it, poure the resident clothin tube. Went into he then removed the ti extension on the fe syringe in the tubin stethoscope to che retrieved 2 cans of in the room, while H without a cap on it changing gloves, oi puts the syringe int tube feeding and gi medications and wit the LPN then unhor recapped the syring gloves, she touche the tube feeding an dressing to the tubin have any soap in th indicated she had s cart. When checked cart and another st 3:15 p.m., R48 had several times, how mask on over the tubin On 3/12/2014 at 10	a and put it in the trach site. I on, the LPN administered the o the neb mask and extension ad placed it on the resident e got out a new feeding syringe d water into a pitcher, touched g and dressing to the feeding r pocket for something and ip of the syringe and put an eding tube. She put the g with air in it and takes a ck for placement. The LPN feeding formula out of the box holding the feeding syringe next to her clothing. Without r the feeding syringe, the LPN o the extension tube to the ives the resident the ater flushes. After finishing , poked the extention tube and ge tube. Without changing her d around the stoma skin site of nd then readjusted the d parts, then put on a clean e site. The bathroom did not he dispenser. But the LPN sanitizer on her medication ed, the sanitizer was not on the aff had to retrieve some. At been out at nurse's desk ever the resident did have rach site.					
		2:45 p.m., LPN-J went into					
			L		1		

Event ID: 477C11

Facility ID: 00989

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		AND HUMAN SERVICES				FORM /	03/31/2014 APPROVED
STATEMENT	SFOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-0391 SURVEY PLETED
		245097	B. WING			03/1) 3/2014
NAME OF P	ROVIDER OR SUPPLIER	J			TREET ADDRESS, CITY, STATE, ZIP CODE		:
FARIBAU	ILT CARE CENTER				738 HULETT AVENUE NORTH ARIBAULT, MN 55021		
(X4) ID PREFIX , TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa R48's room without or gown She laid	age 76 t putting on a mask and gloves a cloth chux on the resident's	F 4	441			
	bed and straightener resident had a mass to cough. When the bathroom to wash h was no soap in the soiled utility room to doors down from the the housekeeper the	ed it out touching linens. The sk over the trach but was noted le LPN-J went into the her hands she noted there dispenser. She went to the o wash her hands. It was 2 he resident's room. LPN-J told he resident's bathroom needed ekeeper went in and filled the		r			
	(NA)/medical recor walked into R48's r or gown on. The a the room and touch on the back. The re- get into bed. The a washing her hands mask and went in t NA-F was interview of a mask over the nurse aides put a r do cares on the res- out of the room, the the room and enco- mask on or they do	2:49 p.m., a nurse aide rds (MR) (NA)-K/(MR)-K room without a mask, or gloves ide directed the resident into ned the walker and the resident esident wanted assistance to aide walked out without s. NA-F put her gloves on and to assist the resident into bed. ved about the resident and use trach area. She indicated the mask over the trach when they sident . If they see R48 come ey redirect the resident back to burage the resident to put a b it for the resident. The bendent with toileting and ls.		· · ·			
FORM CMS 2	in R48's room suct resident was cougl mask but had glov available in the cat door. At 8:30 a.m.,	45 a.m., LPN-B was observed tioning the resident. The hing. LPN-B did not wear a es on. No gowns were binet outside the resident's R48 came out to nurse's desk and 2 staff (NA-K, LPN-J) s Obsolete		Fa	cility ID: 00989 If continua	ation sheet	Page 77 of 82

					FORM	03/31/2014 APPROVED 0938-0391		
T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED		
	245097	B. WING	i			3/2014		
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
ULT CARE CENTER								
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE		
walk by the residen	t for several minutes before	F ·	441					
nursing (DON) was isolation precaution stated masks, glow when doing cares. precautions becaus culture for MRSA re DON on observatio glove exchange, la lack of gowns in the observations of res mask and sometim times not. The DO following the preca	interviewed regarding the as to be used for R48. She es, gowns are to be worn R48 was placed on se the resident had a positive espiratory. Interviewed the ns of poor handwashing and ck of soap in the bathroom, e cupboard and also discussed ident leaving room without a es being directed and other N indicated the staff should be utions because the resident							
precaution sign wa resident's room. On 3/13/2013 at 2: nursing station and minutes until RN-A	s placed at the doorway of the 00 p.m., R48 walked into the stood over RN-A for several was able to direct R48 back to				• • • • •			
(RN)-A was intervie problem coming ou hallways without ke as directed by facil On 3/13/2014 at 1:	ewed. and verified R48 had a to the desk area and in the eeping the trach area covered ity protocol. 30 p.m., the DON was again							
	RS FOR MEDICARE TOF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER ULT CARE CENTER ULT CARE CENTER (EACH DEFICIENCY REGULATORY OR L Continued From pa walk by the residen redirecting the residen stated masks, glove when doing cares. precautions becaus culture for MRSA re DON on observation glove exchange, lat lack of gowns in the observations of res mask and sometim times not. The DO following the precau- was positive for MF set up. On 3/13/2014 at 12 precaution sign wa- resident's room. On 3/13/2014 at 12 nursing station and minutes until RN-A his room as the trad- On 3/13/2014 at 12 problem coming ou hallways without ke as directed by facili On 3/13/2014 at 13	DF CORRECTION IDENTIFICATION NUMBER: 245097 PROVIDER OR SUPPLIER ULT CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 walk by the resident for several minutes before redirecting the resident to get a mask on. On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. R48 was placed on precautions because the resident had a positive culture for MRSA respiratory. Interviewed the DON on observations of poor handwashing and glove exchange, lack of soap in the bathroom, lack of gowns in the cupboard and also discussed observations of resident leaving room without a mask and sometimes being directed and other times not. The DON indicated the staff should be following the precautions because the resident was positive for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precaution sign was placed at the doorway of the	RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES PROVIDER CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245097 B. WING PROVIDER OR SUPPLIER ULT CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 walk by the resident for several minutes before redirecting the resident to get a mask on. On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. R48 was placed on precautions because the resident had a positive culture for MRSA respiratory. Interviewed the DON on observations of poor handwashing and glove exchange, lack of soap in the bathroom, lack of gowns in the cupboard and also discussed observations of resident leaving room without a mask and sometimes being directed and other times not. The DON indicated the staff should be following the precautions because the resident was positive for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precaution sign was placed at the doorway of the resident's room. On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was interviewed. and verified R48 bad a problem coming out to the desk area and in the hallways without keeping the trach area covered as directed by facility protocol. On 3/13/2014 at 1:30 p.m., the DON was again	RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES TOF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 245097 PROVIDER OR SUPPLIER ULT CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 77 Walk by the resident for several minutes before redirecting the resident to get a mask on. On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. 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On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was interviewed. and verified R48 had a problem coming out to the desk area and in the hall	TMENT OF HEALTH AND HUMAN SERVICES O RS FOR MEDICARE & MEDICAID SERVICES O POP DEFIGIENCIES (X2) MULTPLE CONSTRUCTION PEONDER OR SUPPLIER 245097 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 FOR DR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 132 HULETT AVENUE NORTH FARIBAULT, MN 55021 PROVIDER OR SUPPLIER DEPODENCES ULT CARE CENTER PROVIDER SUPPLIER SUMMARY STATEMENT OF DEFICIENCES PROVIDER SUPPLIER IEACH DECINICY WILL TO PRECEDED BY FILL PROVIDERS TAN OF CORRECTION SHOLL REQULATORY ON LSS DENTIFYING INFORMATION PROVIDERS TAN OF CORRECTIO Continued From page 77 Walk by the resident for several minutes before redirecting the resident for several minutes before redirecting the resident for Several minutes before redirecting the resident for Several minutes before stated masks, gloves, gowns are to be worn when doing cares. F48 was placed on precautions to be used for R48. She stated masks, gloves, gown are to be worn when doing cares. F48 was placed on other times not. The DON indicated the staft should be following the precautions because the resident heat prosting to for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precautions ident was positive for MRSA and the precautions were set up. On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was able to direct R48 back to his room as therviewed. Indivers	TMENT OF HEALTH AND HUMAN SERVICES FORM. RS FOR MEDICARE & MEDICAID SERVICES OMB NO. Corp percentiones (X) PROVIDERSUPPLENCLA (X2) MULTPLE CONSTRUCTION (X3) MULTPLE CONSTRUCTION PEOVIDER OR SUPPLER 245097 IVING (X3) MULTPLE CONSTRUCTION (X3) MULTPLE CONSTRUCTION ULT CARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE T738 HULETT AVENUE NORTH PARIBAULT, MN 55021 VECONDERCENT VIST RE PRECEDED BY FULL PREFX PROVIDERS PLAN OF CORRECTION CODE VECOND DESCIDENTFYING INFORMATION PREFX TAG CODES-REFERENCE CODES Continued From page 77 F 441 PROVIDERS PLAN OF CORRECTION ECACH CORRECTION ON LOS BE CODES-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 77 F 441 PATISAULT, MN 55021 FORM. Valid by the resident to get a mask on. PREFX TAG DEFICIENCY Continued From page 77 F 441 F 441 DEFICIENCY Continued Grass Researce to the worn when Coing carse. R48 was placed on precautions to be used for R48. She stated masks, gloves, gowns are to be worn when Coing carse. R48 was placed on precautions of poor handwashing and glove exchange, lack of sogo in the bathroom, lack of gowns in the culton formow without a mask and soont the bathroom, lack of gow mash and sogo for the bat		

		AND HUMAN SERVICES				FORM	03/31/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245097	B. WING		, 	1	C
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 001	
FARIBAU	JLT CARE CENTER				HULETT AVENUE NORTH IBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441		ige 78 tated "[R48], we are unable to n so he is in what we call	F 4	141			
	precaution, but he of that either. We are	does not follow through with constantly taking him to his g the masks to cover the trach					
	NEBULIZER EQUI SANITIZED BETW						
arte ya 2741 - Antonio Antonio - Antonio Antonio	at 10:15 a.m. to be The nebulizer cup a machine. The nebu	stem was observed on 3/12/14 located on his bed side stand. and tubing was attached to the lizer cup where the medication ed with moisture drops on the				J	
	that she had set up medication treatme LPN-B had not cleat the inhalation treat	nurse (LPN)-B was 2/14 at 10:15 a.m. and said and given R10 his nebulizer ent at 8:00 a.m. However, aned the equipment following ment to prevent bacterial <i>r</i> th as outlined in the facility					
	was noted to be ful there was a white f the nebulizer cup. (and care of the neb R10 said, "They [re ever clean it." R10	t 1/17 p.m. R10's nebulizer ly connected and this time ilm coating the entire inside of On asking R10 about the use pulizer equipment at this time ferring to facility staff] don't said that he had used the nt earlier in the day and no one e then.					
		p.m. trained medication was asked about the use and			ID: 00989 If continuat		Page 79 of 82

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DEPARTMENT OF HEALTH AND HUMAN SERV	VICES
CENTERS FOR MEDICARE & MEDICAID SERV	/ICES

PRINTED: 03/31/2014 FORM APPROVED OMB NO: 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED		
		245097	B. WING					13/2014	
	PROVIDER OR SUPPLIER	·		17	TREET ADDRESS, C 738 HULETT AVEN ARIBAULT, MN		DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIV			SHOULD BE	(X5) COMPLETION DATE	
F 441		ige 79 ebulizer equipment following nent. TMA-A said that the	F 4	41					
	be rinsed in water a However, this had r	taken apart and the cup is to and the equipment is to air dry. not been done following R10's t on 3/12/14 8:00 a.m. dose r 8:00 a.m. dose.							
	of following the faci nebulizer equipmer	sing was made aware of lack lity policy on the care of the nt on 3/13/14 at 2:47 p.m. and d for the policy in regards to ation procedure.					1.		
F 465 SS=E	Nebulizer Procedur "11. Administer the depleted (about 10- Disassemble device and nebulizer cup v per facility policy. D facility policy." 483.70(h)	rt Health Group Small Volume es, revised date 06/2013 read, rapy until the medication is -15 minutes)." and "13. e and rinse the mouthpiece vith water and dry. Store unit ispose of equipment per	, F4	-65					
		ovide a safe, functional, ortable environment for the public.			÷.,				
	by: Based on observat failed to keep kitche environment clean keep the physical e	NT is not met as evidenced tion and interview the facility en equipment and the kitchen and sanitary, also failed to nvironment free from foul potential to affect 41 of 43				•	•		

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

Facility ID: 00989

If continuation sheet Page 80 of 82

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					03/31/2014 APPROVED	
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST	RUCTION	(X3) DATE	0938-0391 SURVEY PLETED	
AND PLAN O	FCORRECTION	245097	A. BUILD	ING	<u>.</u>	C 03/13/2014		
	PROVIDER OR SUPPLIER	245097			DDRESS, CITY, STATE, ZIP CODE	03/	3/2014	
					ETT AVENUE NORTH			
FARIBAL	JLT CARE CENTER		5. 1	FARIBAL	JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOUI IOSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 465	Continued From pa residents residing in -potential to staff an	n the facility and had the	F 4	465				
	on 3/10/14 at 1:45 pobserved: Upright freezers an kitchen had a thick and when the grill with entire top of the The ice machine lo observed to have the coat of dust/debris coated with white posterved to have the coat of dust/debris coated with white posterved around the electrical cords and appliances includin coated with a thick emergency pull ring machine had long so During the environma.m. accompanied and lead housekee observed: The bathroom in records and the odor continued housekeeper said	chen had multiple food debris ne perimeter of the room. The d water tubing connected to the ig the coffee maker was layer of dust/debris. The metal g located near the coffee strands of dust/debris. mental tour on 3/13/14 at 8:30 by the director of maintenance eper. The following was oom 113 had a strong urine he toilet had been flushed and to be present. The it sometimes smells and they hroom. However, the urine		03/2 clean equi ident 2. Er com Desi envir 3. St using in ne Staff main 4. We be co Admi a clea 5. If a be ac Quali 6. Th	5 Il staff has been educated 5/2014 by DON related to n environment, clean pment, utilizing a work ord tify areas in need of repair nvironmental audits will be pleted by Administrator/ gnee to ensure a clean sa ronment. aff educated 03/25/14 on g a work order to identify a red of repair and cleaning. educated 03/25/14 on tain a clear hall way. eekly environmental audits ompleted by inistrator/Designee to ensu an safe environment. any issues are identified it ddressed through the facilit ity Assurance meetings. e facility will be in substan bilance by 04/22/2014	er to fe reas s will ire will ty's	4/22/14	
	The 300 wing was	observed to have resident use s Obsolete Event ID:477C1	1	Facility ID: 00	0989 If continu	ation sheet	Page 81 of 82	

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

Event ID: 477C11

Facility ID: 00989

		AND HUMAN SERVICES					FORM	APPROVED	
			()(0) MUU			(0938-0391	
STATEMENT OF DEF	ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		(X3) DAT COM	E SURVEY IPLETED	
								c	
		245097	B. WING			-	03/13/2014		
NAME OF PROVIDE	R OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
FARIBAULT CAI	RE CENTER				JLETT AVENUE NOP	RTH			
				FARIB	AULT, MN 55021				
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAI (EACH CORRECTIVE CROSS-REFERENCED DEFIC	EACTION SHOUL	D BE	(X5) COMPLETION DATE	
equipr		age 81 g wheel chair, weight chair, lown the west side of the	F4	65	•				
hallwa west s reside oppos into ar	y. Also the m side of the hal nts who met ite directions n open door v	edication cart is placed on the llway. There were two each other going in the and one of them had to move vay to allow the other resident							
used t who a the ha asking house	o store reside re ambulatory nd rails on th the mainten keeper it was	the west side of the hallway ent equipment the residents y do not have free access to e west side to the hallway. On ance director and s learned that they have to use							
equipr the ar the ma the ma	nent because ea to keep the aintenance di actice of kee	300 wing to store resident there is no storage room in em. It was also learned from rector and housekeeper that ping resident equipment							
a long		hallway has been practiced for							
								an a	
					u				

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245097	B. WING _		03	/13/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021		
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K 000	INITIAL COMMEN	rs	K 00	1		
×	ALLEGATION OF (DEPARTMENT'S A	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE WILL BE USED AS F COMPLIANCE.		POC 04 (73 4-21-14		
WERLY	ON-SITE REVISIT VALIDATE THAT S WITH THE REGUL	OF A ACCEPTABLE POC, AN MAY BE CONDUCTED TO UBSTANTIAL COMPLIANCE ATIONS HAS BEEN ORDANCE WITH YOUR				21
	Minnesota Departn Fire Fire Marshal D survey, Faribault C compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety - State Division. At the time of this Care Center was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.				
EXIT: 3-13-14	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY		APR 1 7 2014		- - -
12	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145		MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		= 2,,,
JORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	istrator	04	(X6) DATE

FMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SUR COMPLET	VEY ED	
	4 C 1	245097	B. WING	4.	03/13/2	03/13/2014	
	ROVIDER OR SUPPLIER		17:	REET ADDRESS, CITY, STATE, ZIP CODE 38 HULETT AVENUE NORTH RIBAULT, MN 55021			
(4) ID REFIX TAG	TACH 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 CON	(X5) IPLETION DATE	
	Continued From pa By email to: Marian-Whitney@s		K 000	*		12 2 2 2 2 1 	
19) X	THE PLAN OF CO	RRECTION FOR EACH				35) 1	
al. Liye	to correct the defic	what has been, or will be, done iency. roposed, completion date.			~		
3	responsible for con	or title of the person rection and monitoring to ence of the deficiency.					
	partial basement. 2 different times. T constructed in 196 Type II(111) constr constructed to the determined to be o Because the origin are of the same ty construction type a	nter is a 1-story building with a The building was constructed at The original building was 5 and was determined to be of Fuction. In 1992, addition was East Wing that was of Type II(111) construction. The building and the 1 addition pe of construction and meet the allowed for existing buildings, weyed as one building.	22		(a) (a) (b)	ан	
	fire alarm system	y sprinkled. The facility has a with full corridor smoke ces open to the corridors that is matic fire department				2	
K 050 SS=D	census of 43 beds	capacity of 55 beds and had a at the time of the survey. AFETY CODE STANDARD	K 050		<i>.</i>	8499	

DEPARTMENT ()F HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM / MB NO.	04/08/2014 APPROVED 0938-0391
STATEMENT OF DEFICI	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		245097	B. WING			03/1	13/2014
NAME OF PROVIDER	23			173	REET ADDRESS, CITY, STATE, ZIP CODE 38 HULETT AVENUE NORTH NRIBAULT, MN 55021	1	± 8
(AT) ID (EA)	H 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
Fire dri	ied From pa Is are held a	at unexpected times under	ĸ		K050 1. Fire drills will be		2 2
The sta that dril Respon assigne qualifie conduc annour alarms This S ⁷ Based intervie to cond LSC (0 could a Finding On fac on 03/ docum not var shift. 3 PM an at 9:05	ff is familiar Is are part of Is are part of Is ability for p ad only to co d to exercis ted between cement ma 19.7.1.2 TANDARD on review of w,, it was de luct fire drill 0) Section 1 ffect how st us include: is include: is include: is include: is include: is include: is of 4 drills w d 4:50 PM. PM.	is not met as evidenced by: of reports, records and etermined that the facility failed s in accordance with NFPA 101 19.7.1.2. This deficient practice caff react in the event of a fire. ween 09:30 AM and 01:30 PM sed on review of available vas reveled that fire drills were out the shift during the evening vere conducted between 3:15 The fourth drill was conducted			 conducted at an increased varied time to ensure all shifts and are addressed, also making sure the drills are completed at times that are not convenient for staff Monitoring will be completed by Administrator with review of the times of the drills monthly. Education completed with Maintenance Director 04/07/2014 If any issues are identified it will be addressed through the facility's Quality Assurance meetings. The facility will be in substantial compliance by 04/22/2014 	-	316 155 151 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
K 154 NFPA SS=D Where out of period	nance Direc 101 LIFE S/ a required service for r the authori	tice was verified facility of (CB). AFETY CODE STANDARD automatic sprinkler system is nore than 4 hours in a 24-hour ty having jurisdiction is notified, evacuated or an approved fire	к	154	а М	5	- <u> </u>

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TATEMENT OF DEFICIENCIES	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	0938-039 E SURVEY IPLETED
	245097	B. WING		03/	13/2014
AME OF PROVIDER OR SUF	TER	17 F.	TREET ADDRESS, CITY, STATE, ZIP CODE 738 HULETT AVENUE NORTH ARIBAULT, MN 55021 PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETIO
DEFINI (EACH DEF)	ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE
K-154 Continued Free watch system	om page 3 is provided for all parties left by the shutdown until the sprinkler	K 154	K154 1. Separate policies have been developed and		
This STANDA Based on rev to develop a s procedures to automatic fire for more than deficient prac and visitors in 9.7.6.1 Findings inclu On facility tou on 03/13/2014 review and in Director (CB), separate polic	ARD is not met as evidenced by: view and interview, the facility failed separate written policy containing be followed in the event the sprinkler system is out-of-service four hours in a 24-hour period. This tice could affect all residents, staff the event of a fire. 200 LSC Sec		 been developed and implemented to reflect the automatic fire sprinkler system and the fire protection systems if even out of service. 2. Monitoring will be completed by Administrator 3. Education completed with Maintenance Director 04/07/2014 4. If any issues are identified it will be addressed through the facility's Quality Assurance meetings. 5. The facility will be in substantial compliance by 04/22/2014 		

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Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7012 3050 0001 9094 7475

April 8, 2014

Ms. Shelley Solberg, Administrator Faribault Care Center 1738 Hulett Avenue North Faribault, Minnesota 55021

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5097024

Dear Ms. Solberg:

The above facility was surveyed on March 10, 2014 through March 13, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5097061 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793 Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to contact me with questions about this letter.

Sincerely,

Are Kleggse

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697 Email: <u>anne.kleppe@state.mn.us</u>

Enclosure(s)

cc: Original - Facility Licensing and Certification File

				RECEIVED	
Minneso	ta Department of He	alth		APR 1 8 2014	PRINTED: 03/31/2014 FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
			COM	PLIANCE MONITORING DIVISION	С
		00989	1		03/13/2014
	PROVIDER OR SUPPLIER	1738 HUL	ETT AVENU LT, MN 550		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTE	NTION*****	11/22/14		
	NH LICENSING	CORRECTION ORDER	50		
	144A.10, this correpursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these tt a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	complaint investigation of the standard An investigation of	vey was conducted and tion(s) were also completed at		Minnesota Department of Health documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. d to
	epartment of Health / DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

LABORATORY DIRE	CIORS OR PROVIDER/SUP	LIER REPRESENTATIVES	SIGNATURE	111LE		(XO) DATE
Au	elles Ar	1 heron	Ad	minist	nator	04/17/14
STATE FORM			6899 47	77°C11		If continuation sheet 1 of 79

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			/	· ·		;
		00989	B. WING			3/2014
IAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ARIBAU	JLT CARE CENTER		LETT AVENU JLT, MN 550			
(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 AI DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
2 000	Continued From pa	ne 1	2 000			5 - J
2 000	Continued From pa	û e i	2 000	The assigned tag number app far left column entitled "ID Pr The state statute/rule out of c listed in the "Summary Statem Deficiencies" column and rep Comply" portion of the correct This column also includes the which are in violation of the st after the statement, "This Rul as evidence by." Following the findings are the Suggested M Correction and Time period for PLEASE DISREGARD THE F	efix Tag." ompliance is nent of laces the "To tion order. e findings ate statute e is not met e surveyors ethod of or Correction.	
				THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPL FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRE	N OF IES TO NLY. THIS GE. NT TO CTION FOR	
				VIOLATIONS OF MINNESOT STATUTES/RULES.	ASTALE	
2 380	Residents; Telephone Subp. 2. Telephone provide at least one which is accessible case of emergency access to a telepho within the building fe home may charge t distance charges the	2 Subp. 2 Policies Concerning nes es. A nursing home must e non-coin-operated telephone to residents at all times in . A resident must have ne at a convenient location or personal use. A nursing he resident for actual long at the resident incurs.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING			C 1 3/2014
	PROVIDER OR SUPPLIER	1738 HU	DDRESS, CITY, S ⁻ LETT AVENUE JLT, MN 5502 ⁻	NORTH		
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 380	Based on observat review the facility fa telephone usage fo observed using the	ion, interview and document ailed to ensure privacy during r 1 of 1 (R46) residents	2 380			
	During an interview stated not allowed	led privacy during phone calls. y on 3/10/14 at 5:11 p.m. R46 to use the portable telephone taken away. "Make me sit				
	sitting in the hallwa nursing station. The were within hearing 10:19 a.m. R46 state provider. R46 state that the use of the 3/12/14 between 13 observed to use the	on 3/12/14 at 10:05 a.m. y using the telephone in the ree staff and three residents distance. On 3/12/14 at ted the telephone call was to it was to a health care ed did have a cell phone, but cell phone cost money. On 00 p.m. and 3:00 p.m. R3 was be telephone at the nursing When asked, resident stated were not private.				
	admitted to the me The admission Min 11/5/13 indicated th interview of mental no cognitive impair	nts indicated R46 was mory care unit on 11/5/13. imum Data Set (MDS) dated he resident had a brief status score (BIMS) of 13 or ment, displayed no behaviors, ent with all activities of daily				
	The sign stated, " F	outside the memory care unit. Resident phone is not allowed ntil further notice. Thank you."				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		00989	B. WING			C 1 3/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		10/2014
ARIBAL	JLT CARE CENTER		LETT AVENUE			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 380	Continued From pa	age 3	2 380			
	director of nursing was available in the stated it was her un use the telephone residents to use the incident of being at in area was a priva	y on 3/13/14 at 12:10 p.m., the verified no portable telephone e memory care unit. DON inderstanding that R46 would for hours and not allow other e phone. DON verified the the nursing station with staff cy issue, but added the personal cell phone.				
	designee (SSD) on verified the portable the memory care u that the nursing sta use. SSD stated R R46 to have acces	with the social service 3/13/14 at 1:00 p.m., SSD e phone was not to be used in nit. SSD stated R46 was told tion phone was available for 146's guardian did not want s to the portable phone to call e phone at the nursing station				
• 44	The facility could as and that staff are tr	THOD OF CORRECTION: ssure that policies are updated ained to assure residents have one and have privacy during				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
2 540	MN Rule 4658.040 Resident Assessme	0 Subp. 1 & 2 Comprehensive ent	2 540			
	conduct a compreh resident's needs, w capability to perform	ment. A nursing home must ensive assessment of each hich describes the resident's n daily life functions and ents in functional capacity. A				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE COME	SURVEY PLETED
			A. BUILDING:			_
		00989	B. WING			C I 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	-	2
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 540	Continued From pa	ige 4	2 540			·
	nursing assessmer Minnesota Statutes 15, may be used as resident assessme comprehensive res used to develop, re comprehensive pla 4658.0405. Subp. 2. Informa comprehensive res include at least the A. medically de medical history; B. medical stat C. physical and D. sensory and E. nutritional stat F. special treat	at conducted according to s, section 148.171, subdivision s part of the comprehensive nt. The results of the ident assessment must be view, and revise the resident's n of care as defined in part ation gathered. The ident assessment must following information: fined conditions and prior us measurement; d mental functional status; l physical impairments; atus and requirements; ments or procedures; psychosocial status; otential; ion; ential; n potential; tus; r; and				
	by: Based on interview facility failed to ass appropriateness of	ent is not met as evidenced and document review the ess 1 of 1 residents (R46) for placement in the care unit at the time of				
Minnesota De	R46 lacked an asse	essment for the placement on the locked				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		00989	B. WING			C 3/2014
	PROVIDER OR SUPPLIER	1738 HUL	DRESS, CITY, S ETT AVENUE LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 540	11/5/14 directly from initial Preadmission 11/5/13 indicated F management or ins redirection, and have During an interview stated he was only appropriate placem summary dated 11/ stated he did not w Review of the admit (MDS) dated 11/12. (brief interview for no or no cognitive imp displayed no halluc behaviors, no physic displayed no rejection wandering behavior	to the locked dementia unit on n an acute care hospital. The of Screening (PAS) dated R46 needed behavior struction, was resistant to d a history of homelessness on 3/10/14 at 5:06 p.m. R46 50 and felt this was not an ent. The care conference 25/13 indicated R46 had ant to be " locked up " ssion Minimum Data Set (13 noted R46 had a BIMS mental status) score of 13/15 airment. The MDS noted R46 inations, no delusional ical or verbal behaviors, on of care, and displayed no	2 540			
	placement at the Fa appropriate for long unit; an elopement facilities to look for not include interver for continued place unit. Review of the elopement attempts admission. During an interview administrator (ADM why R46 was in the because he was an	aribault Care Center was term care; on the secured risk; had a history of leaving alcohol. The care plan did titons related to re-assessment ment on the locked dementia documentation revealed no s had occurred since on 3/10/14 at 6:30 p.m. the stated that she was not sure dementia unit except elopement risk. ADM stated is was an appropriate				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
		00989	B. WING			C 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FARIRAI	JLT CARE CENTER		ETT AVENUE			
ANDA			LT, MN 5502	1		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLE DATE
2 540	Continued From pa	ge 6	2 540			
2 **	direct of nursing (D could climb out eve DON added she wo appropriate facility.	on 3/13/14 at 12:10 p.m. the ON) stated she believed R46 n with the locked fenced area. ould like to see R46 in an age				
	social service desig	on 3/13/14 at 1:00 p.m. the nee stated she was not able ervices documentation related acement for R46.				
	The director of nurs assure that upon ac assessment is cond which describes the perform daily life fu impairments in func- nursing or designed residents are appro	HOD OF CORRECTION: sing and/or designee could dmission, a comprehensive ducted each resident's needs, e resident's capability to unctions and significant stional capacity. The director of e could monitor to assure that priately assessed to nt in the dementia/memory e of admission.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			
	comprehensive plan objectives and time long- and short-term and mental and psy identified in the com assessment. The c	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are prehensive resident comprehensive plan of care dividual abuse prevention plan				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FARIBA	JLT CARE CENTER		ETT AVENU LT, MN 550			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 7	2 560			
	required by Minnes subdivision 14, para	ota Statutes, section 626.557, agraph (b).				
-	by:	ent is not met as evidenced				
	facility failed to dev residents (R40, R7	and document review, the elop a plan of care for 2 of 3 0) identified as a fall risk, failed				
		f care that included al interventions for 2 of 5 7) reviewed for unnecessary				
	Findings include:					
	bedroom. The falls	aree, unwitnessed falls, in his occurred on 3/5/14, at 12:53 6:45 p.m. and on 3/9/14 at				
	initiation date of 1/1 1/20/14 revealed th	of care for R70 with an 0/14, and a revision date of at there were no goals or ssing falls or falls with				
	Set (MDS) form dat limited to, hyperter weakness. The MD falls with fracture 2-	osis from the minimum Data ted 1/16/14, lists but is not asion, anxiety and muscle S further indicated a history of 6 months prior to admission. essment addresses falls as a				
	dated 1/16/14, indi	w for Mental Status (BIMS) cated a summary score of 14 for cognitive patterns ly intact.				
Minnesota De STATE FORM	epartment of Health		6899	477C11	If continuati	on sheet 8 of 79

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER** FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 560 Continued From page 8 2 560 When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address the resident's history of falls and did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care plan (on admission) should have addressed falls with interventions since the resident had a history of falls. R27's plan of care did not address parameters for use of an anti-anxiety medication and did not address use of non-pharmacological interventions prior to the administration of anti-anxiety medications. R27 was on multiple scheduled psychotropic medications, which were

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STATEMEN	ta Department of H	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY
		00989	B. WING			C I 3/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS. CITY, S	STATE, ZIP CODE	03/	13/2014
FARIBAU	JLT CARE CENTER	1738 HUI	ETT AVENUE	ENORTH		
(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)	I SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 9	2 560			
	not addressed on t	he plan of care.				
	altered mental stat toes, sedative/hypr nondependent can hypertension, esop dependence abuse drug-induced psycl	2014 with dx (from care plan) us, traumatic amputation of notic /anxiolytic dependence, nabis abuse, diabetes, phageal reflux, opioid type e, dissociative identity disorder, hotic disorder with anoid schizophrenia,			•	
 	on Clonazepam 0.8 severe anxiety. Th	cations were Buspar, Elavil,				
in Linear	reviewed. The res clonazepam (antial times in both mont	dated 2/2014 and 3/2014 were ident used the as needed nxiety medication) several hs. The scheduled other cations were given as ordered.				
	of 2/20/2014 was re documentation reg necessary anti-anx address what non	tiated 2/5/2014 and print date eviewed. The care plan lacked arding the use of the as iety medication and did not pharmacological interventions efore giving the as needed anti				
	non-pharmacologic	also lacked documentation of cal interventions attempted stration of as necessary tion.				
dinnesota De	interviewed regardi	2:50 p.m., the DON was ng use of as necessary (prn) tion and stated that non				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00989	B. WING			C 1 3/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
FARIBAI	JLT CARE CENTER		LETT AVENUE				
		FARIBA	ULT, MN 5502	21			
(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 SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 10	2 560				
	attempted prior to t medication. DON s have been develop	terventions should be he as needed anti anxiety tated the care plan should ed to identify the use of the the non pharmacological					
	needed antianxiety anxiety, monitoring,	al interventions prior to					
	1/9/2014 identified	ary from the hospital dated R40 used as needed ety and every bedtime for				:	
	falls, schizoactive d compression of bra alcohol use, intrace	2014 with diagnoses hx of isorder, paralysis agitans, in, parkinson's disease, hx of rebral hemmorrhage, phalus, insomnia (on MD					
	Lorazepam 0.5 mg needed for anxiety;	ated 1/16/2014 identified by mouth every 6 hours as and Lorazepam 0.5 mg (4 outh at bedtime as needed for	r				
	Lorazepam (antian) necessary for sleep	heets were reviewed: kiety medication) was used as and/or anxiety: 1/149 ed 23 times and in 3/14-it					
Minnesota De		dated 1/13/2014, was ed the resident had difficulty					

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	LETED
		00989	B. WING	·		C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pa	ige 11	2 560			
	staying asleep; rela history of taking sle to bedtime. An aver hours. R40 had ne Parkinson's disease environmental factor sleeping difficulties assessment was a	ted to pain; did not have a eep medications routinely prior rage length of nap was 1-2 urological deficits (stroke, e, seizure disorder). No ors contributing to resident was identified. The collection of data but did not or analysis of the data to				
	and print out date o did not address R44 needed antianxiety lacked documentati pharmacological in	h initiated date of 1/14/2014 of 2/20/2014 was reviewed. It O's sleep issues or use of as medications. The care plan ion regarding what non herventions should be iving the as needed anti				· · · · · · · ·
		also lacked documentation of al interventions to be he administration of				
	assistant (TMA)-C v of the antianxiety m she did not give the and indicated R40 v night for sleep. TMA-C stated the r used it throughout t was up and about.	:45 a.m., a trained medical was interviewed regarding use redication. TMA-C indicated e medication during the day was given the medication at esident got anxious but rarely he day because the resident The TMA did not know if there prior to giving the medication.				
Minnesota D	DON was interview	:50 p.m. and 1:05 p.m., the ed regarding criteria for use of ion. She stated they should				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_	
		00989	B. WING			C 13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE			
FARIBAU	JLT CARE CENTER		LETT AVENU JLT, MN 5502				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 12	2 560				
	to administering the be following up for checked for sleep r indicated it was not	nacological interventions prior e medication and should also effectiveness. DON also nonitoring for R40 and being done, DON said that 40 was not based on sleep					
	The director of nurse assure that policies implemented, that s monitoring is done are developed for re	HOD OF CORRECTION: sing and/or designee could and procedures are updated, staff are trained and that to assure resident care plans esidents at risk for falls and logical interventions are ed and evaluated.					
	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				
		omprehensive plan of care personnel involved in the					
Minnesots	by: Based on observati review the facility fa was followed for 1 c with urinary incontin	ent is not met as evidenced on, interview and document iled to ensure the care plan of 3 residents (R25) observed hence and 1 of 3 residents assistance with hearing aides.					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
		00989	B. WING			C I 3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 13	2 565			
	Findings include:					
	accordance with the	e incontinence care in e plan of care. During three tinence care exceeded the 2 ne care plan.				
	care plan had a foc toileting" and direc 2 hours and per rec	ed 2/13/14 was reviewed. The us of, "staff assist with ted staff to offer toileting every quest. On 2/13/14 a change are plan that directed a check ule.				
	observed to be lying two soaker pads un observed to be prov 3.5 hours. On 3/12 10:25 a.m. to 1:30 g be provided contine Nursing assistant (I repositioned and as total of 3.5 hours. If at 12:00 p.m. to 1:3 received incontinen hours) NA-J stated to R25 at 10:00 a.m 3/13/14 R25 was of a.m. and no incont NA-C stated she ha	00 pm to 7:30 p.m.R25 was g on his back in bed. R25 had oder him. R25 was not vided incontinence cares for /14 R25 was observed from p.m. R25 was not observed to ence cares for 3 hours. NA)-J stated she had last asisted R25 at 10:00 a.m. or a R25 was observed on 3/12/13 i0 p.m. At 1:30 p.m. R25 ince care (by observation 1.5 I she had last provided cares n. (a total of 3.5 hours) On pserved from 7:09 a.m. to 8:58 inence cares were provided. ad worked all night and had epositioned R25 at 5:30 a.m. purs).				
Minnesota Da	3/13/14 at 11:45 a.r expect the care plat resident refused ca	sing (DON) was interviewed on n. DON stated she would n to be followed. If the res, she would expect staff to es. DON stated she had not				

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Minnesc	ta Department of He	alth		,		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00989	B. WING		03/1) 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 14	2 565		in a second the second second	
	been contacted by receive incontinenc	staff related to R25 refusing to e cares.				
	and batteries accor	assistance with hearing aides ding to the plan of care.				
	am at risk for socia of hearing. Make ce aides prior to the st Furthermore, the pl	an of care revised 7/10/13, sive hearing loss. Potential for				
	7:00 p.m. R4 was c able to hear despite present in the left e the missing hearing not know what the f or replacing the hea NA-B came into the did not know what h or why the one in th When asked how d shrugged shoulders work, I'm used to he attempted to chang could not hear the co answer questions.	and interview on 3/10/14, at omplaining about not being a having a hearing aide ar. R4 said she had reported aide to her right ear, but did acility was doing about finding aring aide. Nursing assistant a room and when questioned happened to the hearing aide te left ear was not working. o you communicate NA-B s and stated, "We make it er." The nursing assistant e the battery for R4 but R4 conversation which surveyor mputer for R4 to read and				
Minnesota Do	R4 was on her way not have her hearin designee (SSD) wa hearing aides and c	to the beauty shop and did g aides in. The social service s questioned about the lid not have a missing item or vas not aware the right hearing				

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Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		00989	B. WING			C I 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	she found the heari	About 1:00 p.m. the SSD said ng aides in the medication n R4's ears and she can hear ng just fine.				
	stated, "This is not ear) these are my c	p.m. R4 was interviewed and the new one, (pointing to right Id hearing aides that don't able to hear surveyor.				1.1.1
		verified she did not know the issing and thought R4 had the eek.				
	The director of nurs assure that care pla implemented, staff	HOD OF CORRECTION: sing and/or designee could ans are up to date, trained and staff monitored to ns are being followed.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from th	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 ne attending physician that the in in bed or the resident bed.				
Ainnesota De	epartment of Health					

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Minneso	ta Department of He	alth			I Onivi	AFFNOVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
		00989	B. WING			C I 3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENU			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	by: Based on observati review, the facility facare and services w assessment, develor monitoring related t residents (R39, R46	ent is not met as evidenced on, interview, and document ailed to ensure the necessary vere provided, based on opment of a care plan, and o pain management for 3 of 3 5, R29) who were reviewed for ent (R25) who was reviewed es.				
	Findings include:					
	and was not compre- to develop effective interventions to min- identify which as ne	ing migraine headache pain ehensively assessed for pain non pharmacological imize pain, develop criteria to eded pain medication was to effectiveness of as necessary en administered.				
	nurse for pain medi the bedroom doorw nurse shut the light would get some or o 6:49 p.m., the resid in the chair and the migraine and would time but maybe tom medical assistant (7 with the medication	80 p.m., R39 was looking for a cation. R39 was standing in ay with the call light on. The off and told the resident she check on the medication. At ent was sitting in the bedroom resident indicated had a rather not interview at that forrow. At 7:00 p.m. a trained TMA)-C went down the hall cart but didn't stop to give pain medication for the				
	migraine. At 7:10 p. and stated she was	m., TMA-C was interviewed s just told about the Tylenol after the resident requested				
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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	• ·		B. WING			0
		00989			03/1	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FARIBA	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	ask R39 what the p she would check an have it. At 7:15 p.m said the last time th at 1:45 p.m. and co received it every 6 have oxygen on co The TMA indicated 7:45 p.m. then coul 2 tabs. The TMA s out why R39 was g requested pain med	break, and she was going to bain medication was for and and see if the resident could n., TMA-C came back and be resident had the Tylenol was uldn't have it because hours. R39 was suppose to ntinuously but wouldn't do it. the resident had to wait til d have the Tylenol ES 500 mg tated they are trying to figure etting the migraines and dication every night at this ological interventions were not d.				
	sitting in the dining bath today and was a.m., was observed on and then sitting At 11:50 a.m., was the lights off. At 1:2 requesting a pain m	00 a.m., R39 was observed room and stated didn't take short of breath. At 10:00 I up and about without oxygen in the lobby without oxygen on. observed resting in bed with 20 p.m. was in bed resting and nedication for headache. Non rerventions were not offered or				
	edge of bed. At 1:2 the window, and st	45 a.m., R39 up and sitting on 20 p.m. in lobby, looking out ated feeling better today, and eadache. At 3:20 p.m., R39 ned room resting.				
	and at 9:00 a.m. wa resting. At 11:46 a.	00 a.m., R39 was out of room as in room laying on the bed m., the resident was up being outside and would not ten to.				
Managata		d to the facility on 6/12/2013				
Minnesota D STATE FORI	epartment of Health VI	·	6899 4	477C11	If continuatio	n sheet 18 of 79

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Minnesc	ta Department of He	alth					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 18	2 830				
	diagnoses on the co obstructive pulmon carrier, cardiac dise	h was listed in the medical omputer and included: chronic ary disease, hepatitis C ease, esophageal reflux, aine abuse, drug-induced a, and hypertension.					
	9/20/2013 identified cognitive impairmen regime, received as and occasional pair The intensity of the significant change is the resident's cogni scheduled pain regi medication offered;	n Data Set (MDS) dated the resident with moderate nt, on a pain medication a necessary pain medications, n affected activities and sleep. pain was rated as 8. A MDS dated 2/7/2014, identified tive status as moderate, no me; as necessary pain pain was present, almost affect sleep or activities. The was rated at 7.					
	The resident was id type headache, and which was increase recommended. (ad scheduled for 4/2/2 had chronic tension every 6 hours was s medication. No imp medication, minima some improvement noted and with ong morphine medication	ed 2/26/2014 were reviewed. entified with chronic tension I was on Depakote medication ed. A Neurology consult was cording to staff appointment is 014). 1/29/2014, the resident type headache and Ibuprofen started and Depakote provement with tramadol I improvement with Tylenol, with morphine but daily use bing pain. The tramadol and ons were discontinued.					
	and 12/14/2013, bu come up with a sum plan identifying crite which pain medicat	was completed on 7/12 2013 at the data was not analyzed to amary of the pain issues, a eria to be used to determine on to be given and a plan for al interventions to be used.					

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Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c	
		00989	B. WING		03/1	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	The resident was o medications.	n 3, as necessary, pain				
	following: For 12/2 mg every bedtime; as necessary for h 12/15-12/31) and T hours as necessary used tramadol ever times, lbuprofen 40 was used 3 x for he mg ES every 6 hou times, and morphir needed for modera many times. For 2/2 mg daily as necess times; used the ibu and the acetaminop	eets were reviewed for the 013, R39 used Tylenol 1000 tramadol 50 mg every 6 hours eadache used (8x from ylenol ES 500 mg every 6 of for pain; for 1/2014, R39 y 6 hours as necessary 26 0 mg every 6 hours as needed eadache, acetaminophen 1000 rs as needed used many ne sulfate every hour as te to severe pain was used 2014, R39 was on Imatrex 100 sary. The resident used it 15 profen medication many times ohen 1000 mg ES many times.				
	None of the as need criteria to identify we which of the many a for the resident's part Non pharmacologic effectiveness of the were not consistent R39's care plan with indicated the follow intermittent headac interferes with my a doesn 't interfere we ADL's. My pain ma scale. On 10-13 my testing (CD scan of sleep study) and on	al interventions or as needed pain medication ly documented. h print date of 2/13/2014 ing: I have frequent hes (chronic for me). Pain bility to sleep at times, but vith my ability to do my own y be as bad as 7/10 on a pain y provider ordered extensive sinus, neurology follow up, nee ordered I refused all of				
Minnesota D	this. Interventions: epartment of Health	anticipate my need for pain				

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Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY PLETED
	•		A. BOILDING			С
		00989	B. WING			13/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		LETT AVENU JLT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 830	relief and respond i effectiveness of pa call for assistance. controlled by Topar Ibuprofen. Use of in history of poly-subs effects of pain med necessary Tylenol, interventions such techniques, docum On 3/13/2014 at 12 assistant (TMA)-C of as needed (prn) documentation. TM document prn pain (medication admini effectiveness or fol completed. On 3/13/2014 at 12 director of nursing regarding pain asse needed pain medic assessments were of the data was not plan. The use of pi medication should and follow up for eff MAR. The staff wer form in front of the included all the con MAR's did not have and the DON stated There should be critical	 Immediately. Evaluate the in interventions, I am able to I prefer to have pain nax, melatonin, Tylenol and harcotics is discouraged due to stance abuse. monitor for side prior to administering as utilize non-pharmacological as ice for my head, relaxation ent effectiveness. 2:30 p.m., a trained medical was interviewed regarding use pain medications and <i>N</i>A-C stated they are to medication on back of MAR stration record) and low up, but not always 2:50 p.m. and 1:05 p.m., the (DON) was interviewed reasing at collection but an analysis completed to determine a rn (as necessary) pain be documented on the MAR fectiveness should be on the re to use a pain management MAR for each resident which nponents. When checked, the a the pain management forms d the staff were not doing it. 		DEFICIE	ENCY)	
Minnocoto	find the criteria. The DON also state	and when and she could not ed Non pharmacological d be attempted prior to the				
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Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		с	
		00989	B. WING		03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		ETT AVENU			
	STIMMADY STA		LT, MN 550	PROVIDER'S PLAN OF CORRECTI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE COMPLETE	
2 830	Continued From pa	ige 21	2 830			
	medication adminis	stration.				
	R46 lacked a comprehensive pain assessment, lacked a plan of care with non-pharmacological interventions for pain and lacked monitoring related to pain management.					
	care conference su indicated R46 had	to the facility 11/5/13. The Immary dated 11/25/13 diagnoses that included rsisting dementia, bipolar natic brain injury.				
	400 mg 1 tab by mo needed for pain, lid	gned 2/5/14 include ibuprofen outh three times daily as ocaine 5% patch apply 1 patch n for 12-hours off for 12-hours,				
	stated he had pain he had numb feet. was asked if he had ankle and foot num wanted the lidocain stated he had back 10. R46 stated he patch placed on his stay put. R46 was survey 1/10/14 thro	on 3/10/14 at 5:00 p.m. R46 but would not rate it. Stated On 3/13/14 at 7:45 a.m. R46 d pain. R46 stated he had bness and that was where he e patch placed. R46 also pain that he rated at a 7 out of did not want the lidocaine back because it would not observed on all days of the ugh 3/13/14 to transfer come to a stand, and walk				
	reviewed. As needed January for complated documentation of n document the inten non-pharmacologic attempted or if the n	ministration record was ed ibuprofen was given twice in ints of back pain. The ursing observations did not sity of the pain or if any al interventions had been medication had been effective.				
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	••		-	4//011	in continuation sheet 22 of 78	

Minnesota Department of Health						
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			-
		00989	B. WING			C 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIRAI	JLT CARE CENTER	1738 HUL	ETT AVENU	ENORTH		
	-		LT, MN 5502	21		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22	2 830			
	during February. N recorded four times given for mouth pai pain or if any non-p had been attempted observations indica given once during t	brofen was given 6 times ursing observations were indicating the medication was n but lacked intensity of the harmacological interventions d. Three of the four ted relief. Ibuprofen was he first 2 weeks of March. Ins did not record the ministered.				
	reviewed. Pain was	inistration record was s documented once per shift umentation indicated R46 did n				
	2/5/14. The assess experienced pain fr on a scale of 00-10 addressed). The ca for pain dated 11/25 experienced pain at the pain was almos findings indicated R ankle injury and wa physician. The CA frequency or intensi non-verbal indicator signs and symptom potential causal fac	ssessment was completed on sment indicated the resident equently that was rated at 4 (mild to severe intensity not are area assessment (CAA) 5/13 indicated the resident t a scale rating of 6 and that t constant. The analysis of 46 had pain related to an s being managed by the A did not evaluate the ity of pain, if there were any rs of pain, or any associated s related to the pain, any tor of pain, or the y pain management program.				
	of pain medication v administer medicati care did not identify	nted 2/18/14 indicated a focus with an intervention to on as ordered. The plan of where the pain was located acological interventions to o manage his pain.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			C	
	No of the second se	00989	B. WING			3/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 5502				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From pa	ige 23	2 830				
	director of nursing pain medications n location, intensity a she had just update	r on 3/13/14 at 12:10 p.m. the (DON) stated with as needed urses were to document pain nd effectiveness. DON stated ed the care plans, but that all nsible for keeping the care					
		prehensive pain assessment nt of a plan to manage the					
	R29 was slow to co bed. R29's face ap her back hurt. R29 burned because of observed during no p.m. R29 was eating	on 03/11/2014 at 10:27 AM. ome to a sitting position in the opeared pained. R29 stated also stated that her mouth decayed teeth. R29 was on lunch on 3/12/14 at 12:23 ng a regular diet independently t what she called meat burned.					
	diagnoses listed on record as osteopor and pain. R29 had Acetaminophen 32	to the facility in 2009. R29 had the medication administration osis, depression, dementia, a physician's order for 5 mg tablet. 2 tabs by mouth 4 No as needed medication found.					
	the resident compla intermittently and h R29 had a physicia Tylenol 325 mg tab	ad a diagnoses of lumbago. n's order dated 10/12/11 for lets 2 tabs four times daily.					
Minnaaata D	The quarterly Minin	num Data Set (MDS) dated					

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Minnesc	ta Department of He	alth				
•	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE COMP	SURVEY
		00989	B. WING		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
			ETT AVENUE			
FARIBAL	FARIBAULT CARE CENTER FARIBAU		LT, MN 5502			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 24	2 830			
	interview for menta cognitive impairmen had pain and that n	used. The frequency and				
	was reviewed. The "presumably the lac BIMS is a result of t CAA noted : numer and that resident in	essments (CAA) dated 8/5/13 nutritional status CAA noted of concentration on the the oral pain." The pain status ic rating scale for pain at a 6 dicated she had pain almost A noted pain managed by				
	The facility pain ass indicated denied pa pain occasionally. of 00-10 at a 3 or m indicated R29 would when in pain and re The assessment div was located, what w the pain and if an a	sessment dated 1/11/14 in, but stated she experienced R29 rated her pain on a scale hild. The assessment d display facial expression eceived scheduled Tylenol. d not indicate where the pain vere potential causal factors of ssessment for the cognitively pain had been conducted.				
	reports moderate parthritis of hips and scheduled use of Ty as per MD orders a Give PRN meds for medications ordere pains and discomfo complaints and non care plan lacked no interventions to ass Care plan problem as indicated by occa	ed 2/13/14 had a focus: ain frequently related to back. Interventions: ylenol. Administer medication nd note the effectiveness. breakthrough [no PRN d] acknowledge presence of rt. Document/report -verbal signs of pain; The n-pharmacological ist R29 to manage her pain. focus: dental health problems asional oral pain. The ed: coordinate arrangements				
vinnesota De	epartment of Health					

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Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
		00989	B. WING		03/1	C 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1738 HUL	ETT AVENU	ENORTH		
FARIBA	JLT CARE CENTER	FARIBAU	LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 25	2 830			
- 476 ti	PRN symptoms of The care plan lacke	nitor/document/report to MD oral pain needing attention. ed non-pharmacological sist R29 to manage her oral				
	3/13/14 at 12:36 p. aware of dental issue resident 's mouth to not sure the facility cognitively impaired been an issue for F complained of back the care plan shoul	sing (DON) was interviewed on m. DON stated she was ues, but unaware of the burning. DON stated she was had a pain assessment for the d, but did know that pain had 829. DON stated R29 k pain last week. DON stated d be revised as necessary and low the plan of care.				
		led appropriate positioning hair or when in bed during				
	7:30 p.m. lying in be elevated. At 6:05 p and the head of the R25 was observed the foot of the bed a he sat in an upright Licensed practical r resident higher in th up without assist of at 8:25 a.m. R25 w head of bed elevate been provided to th (RN)-A came to the the resident. RN-A positioned in order to find someone to	on 3/10/14 from 4:00 p.m. to ed with the head of the bed o.m. R25 received his meal bed was elevated further. to have feet extended beyond and was not positioned so that position to eat safely. hurse (LPN)-I repositioned the bed by pulling the resident 2 staff members. On 3/13/14 vas observed lying in bed with ed and a breakfast tray had e resident. Registered nurse resident's room to observe stated the resident was not to eat the meal safely and left help with assisting the				· · · · · · · · · · · · · · · · · · ·
	resident to repositio	on in the bed.				
Minnesota D	epartment of Health					

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Minnesc	ota Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00989	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EADIDAL			ETT AVENU			
	JLT CARE CENTER	FARIBAU	LT, MN 550	21		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 26	2 830			
	dated 11/7/13 did n positioning and eat printed 2/13/14 iden assist with ADLs. I 2 to boost up in bea with eating, but did	sessment for nutritional status ot identify R25's safety with ing in bed. The care plan ntified a focus/problem of need nterventions included assist of d dated 2/17/14, independent not direct the resident was to safe positioning to eat in bed.				
	in the wheelchair. the back of the whe the floor, R25's was that his thighs were The wheelchair cus edge of the chair.	a.m. R25 was observed sitting R25's back was not against eelchair, R25's feet were on s sitting forward in the chair so e beyond the edge of the chair. shion was beyond the front When asked R25 stated he e sitting in the chair.				
	stated she had just wheelchair and nev	a.m. occupation therapist provided R25 with a larger v cushion, but that she had not vheelchair positioning.				
	focus/problem of ne Interventions incluc mobility on the unit, almost every time. and ask again kind needs to be reported	ed 2/13/14 identified a eed staff assist with mobility. led use a wheelchair for , will refuse to reposition Explain why it has to be done ly. If I am non-compliant it ed to nurse and if nurse cannot osition, report to director of				
	director of nursing (expected to follow t would refuse cares epartment of Health	on 3/13/14 at 11:45 a.m. the (DON) indicated staff were the care plan. If the resident , staff should then re-approach				
STATE FOR	N		6899	477C11	If continuation	n sheet 27 of 79

	Vinnesota	Department of Health
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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00989	B. WING		03/1) 3/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
FARIBAU	JLT CARE CENTER		LETT AVENU JLT, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / 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) COMPLETE DATE	
2 830	had refused to be resident assessment	stated she was unaware R29	2 830				
2 910	Incontinence Subp. 5. Incontinent have a continuous management to red unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident wh receives appropriat prevent urinary trac much normal bladd	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to at infections and to restore as ler function as possible.	2 910				
Minnesota De STATE FORM	epartment of Health M		6899	477C11	If continuation	n sheet 28 of 79	

Minnesc	ta Department of He	alth			1 OI WI	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00989	B. WING		03/1	; 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
			ETT AVENU			
FARIBAU	JLT CARE CENTER		LT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ae 28	2 910			
	by: Based on observati review the facility fa comprehensive urir	ion, interview and document alled to ensure a nary incontinence assessment rvices for 2 of 3 (R25, R46)				
	Findings include:					
	assessment that in	orehensive incontinence cluded voiding patterns and services in accordance with				1. 1948 - 1947 -
	1/24/14 was review diagnoses of deme disorder. The MDS total dependence o living-including toile	imum Data Set (MDS) dated red. The MDS identified ntia, depression, psychotic of 1/24/14 indicated R25 had n two staff for activities of daily eting care; did not have a vas always incontinent.				
	Assessment check R25 had incontinen and impaired mobil functional incontine documented. The Intervention Guideli completed check lis	owel Continence Risk list dated 2/13/14 indicated ice related to mental confusion ity and therefore had nce. No analysis of data was Urinary Continence ine Tool dated 2/13/14 had a st that identified R25 as having nce and recommended an				
	bladder elimination elimination pattern, voiding. The Tool of data to determine w were noted and wh elimination tracking Continence Risk As	n, scheduling of a 3 day tracking to establish and implementing prompted lid not have an analysis of why the recommendations at the outcome of the bladder was. The Urinary and Bowel sessment and Urinary ntion Guideline Tool did not				
	epartment of Health					
STATE FOR	VI		6899	477C11	If continuation	sheet 29 of 79

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Minnesc	ta Department of He	ealth				ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00989	B. WING			C I 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, :	STATE, ZIP CODE		
			ETT AVENU			
FARIBAU	JLT CARE CENTER	FARIBAU	LT, MN 550	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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) COMPLETE DATE
2 910	Continued From pa	ige 29	2 910			
	identify other contri	buting factors such as physical				*
		cal factors, behavioral factors,				
		edical diagnoses factors. A				
	care plan was not c assessments and e	•				
	assessments and e					
		essment (CAA) dated 11/7/13				
		ired extensive assistance for				
		ways incontinent. The noted R25 was highly				
		. The CAA identified urinary				
	urgency, diabetes,	congestive heart failure and				
		ributing factors, but did not				
		incontinence or the voiding The CAA did not provide a				
	plan of care based					
5.E	•					
		ed 2/13/14 was reviewed. The				
		us of "staff assist with ted staff offer toileting every 2				
		est. On 2/13/14 a change was				
	made to the care pl	an that directed a check and				
	change schedule.					
	On 3/10/14 from 4:0	00 p.m., to 7:30 p.m., R25 was				
		g on back in bed. R25 had two				
		him. R25 was not observed				
		ntinence cares for 3.5 hours.				
		a.m., while visiting R25, a as detected. On 3/11/14 at				
	0	observed sitting in the				
	wheelchair. A strong	g urine odor was detected and				
		pants was observed to be				
		R25 was observed from 10:25 25 was not observed to be				
		ce cares for 3 hours. Nursing				
		ated she had last repositioned				· · ·
		t 10:00 a.m. or a total of 3.5				
		served on 3/12/13 at 12:00				
Minnesota D	p.m. to 1:30 p.m. A	At 1:30 p.m. R25 received				
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00989	B. WING		03/1) 3/2014
	PROVIDER OR SUPPLIER			TATE, ZIP CODE	03/1	5/2014
			ETT AVENUE			
FARIBAU	JLT CARE CENTER		LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 30	2 910			
	incontinence care (NA-J stated she ha 10:00 a.m. (a total was observed from incontinence cares she had worked all	by observation 1.5 hours) d last provided cares to R25 at of 3.5 hours) On 3/13/14 R25 7:09 a.m. to 8:58 a.m. and no were provided. NA-C stated night and had last changed 25 at 5:30 a.m. (greater than				
	stated two soaker p	on 3/12/13 at 1:30 p.m. NA-J bads were under the resident se he "wets a lot and this ugh."				te ge 1 − 2 − 2 − 1 − 1 − 1 − 2 − 1 − 1
	3/13/14 at 11:45 a.r incontinence asses completed. The as	sing (DON) was interviewed on m. DON stated the urinary sments were just being sessment was to include a 72 dder diary to see if a pattern				
e governe Le constante Le const	exists. The notatio be included on the would expect the ca resident refused ca re-approach for car	ns on the assessments should care plan. DON stated she are plan to be follow. If the res, she would expect staff to res. DON stated she had not staff related to R25 refusing to				
	R46 lacked a comp plan of care for inco	prehensive assessment and pontinence.				-
Manageria	strong urine smell v nurse (LPN)-I state was unsure if the o resident. LPN-I stat cleaned up. No stat incontinence or odd at 10:05 a.m. and a	on 3/10/14 at 4:10 p.m. A was noted. Licensed practical d he also noticed the odor but dor was from R46 or another red R46 did not like to get off interventions related to the pr was observed. On 3/12/14 at 10:25 a.m. R46 was the nursing station with 3 staff				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENU JLT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	N SHOULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 31	2 910			
t sa	noted. No staff inter incontinence and of 3/13/14 at 7:10 a.m	dor were observed. On . a strong urine odor was observed to be wearing the				
	nursing assistant (Nodor, when near F4	on 3/13/14 at 7:50 a.m. JA)-C verified a strong urine 6. NA-C stated R46 was to a week. NA-C was not ne.				
	Summary dated 11/	11/5/13. The Care Conference /25/13 identified diagnoses of rsisting dementia, bipolar latic brain injury.				.4
	11/12/13 and the que both identified R46	imum Data Set (MDS) dated uarterly MDS dated 1-12-14 as having a BIMS score (brief I status) of 13 or no cognitive always be continent.				
	December docume every other day due documented the res was not given the o Conference Summa	rd for November and nted R46 was to get a shower to incontinence but sident frequently refused or pportunity. The Care ary dated 11/25/13 noted te [sp] in pants and refuse to				
Minnesota De	Bowel Continence F checklist identified i without documentat that a physician exa identified nocturia, a	y completed Urinary and Risk Assessment. The mpaired bladder emptying ion of a post void residual or am had been completed, and determined the resident acteristics of overflow				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
	x	00989	B. WING		C 03/13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 5502		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETE
2 910	Continued From pa	ige 32	2 910		
•	incontinence and cl bladder/urge incont not identify other co physical factors, ps factors, medication factors. The asses of care based on th	haracteristics of over active tinence. The assessment did partributing factors such as ychological factors, behavioral s and medical diagnoses sments did not provide a plan the evaluation. No CAA was or urinary incontinence.			
ана 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	reveal a plan/interv manage incontinen the resident as inde living. The care pla	plan dated 2/18/14 did not entions to assist R46 to ce. The care plan identified ependent with activities of daily an also directed if the resident director of nursing was to be			
	3/13/14 at 11:45 a.r incontinence asses completed. The as hour bowel and bla	sing (DON) was interviewed on m. DON stated the urinary sments were just being sessment was to include a 72 dder diary to see if a pattern d she had not been notified of			
	The director of nurs assure that policies that staff are trained each resident is ass that a continuous p management is imp reduce incontinence incontinent of blado	blemented and evaluated to e and that a resident who is der receives appropriate ices to restore as much			
		R CORRECTION: Twenty One			
Minnesota D	epartment of Health				

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Vinnesota Department of Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. DOLDING		c	
		00989	B. WING		03/13/	2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 550			
(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)	DBE ((X5) COMPLETE DATE
2 910	Continued From pa	ge 33	2 910			
	(21) days.				-	
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			
	Subp. 6. Activities comprehensive resi home must ensure B. a resident who activities of daily livi	of daily living. Based on the ident assessment, a nursing that: is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure provision of resident (R25) observed who with grooming.	,			
	Findings include:					
	R25 lacked persona hair.	al grooming to remove facial				
	dated 1/24/14 identi dementia, depressio	erly Minimum Data Set (MDS) ified diagnoses of diabetes, on, psychotic disorder. The tal dependence of two staff for ing.				
	3/10/14 through 3/1 R25 was noted to b 10:25 a.m. R25 was	throughout the survey of 3/14. On 3/11/14 at 9:30 a.m. e unshaven. On 3/12/14 at s noted to be unshaven. On ., R25 was again observed to				
		d on 3/11/14 at 8:38 a.m. R25				
viinnesota De	epartment of Health					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00989	B. WING		1	C 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENUI LT, MN 5502			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 34	2 920			
	stated that staff wor day and had not sh	uld only shave him every other aved him this day.				
	behavior problems. resistive to cares st determine the optio leave and re-approx resistive. The care resistive to care wit resist ADLs, reass minutes later and tr identified a focus ne interventions for gro assist of 1 staff and comb own hair and interventions did no related to shaving. During an interview nursing assistant (N aid (TMA)-E stated	ed 2/13/14 identified a focus of Interventions directed if aff should have a nurse n that is least detrimental; ach later if continued to be plan identified a focus of h interventions that directed if ure, leave and return 5-10 y again. The care plan eeds assist with ADL's and booming that directed staff need encourage participation to brush teeth. The t provide staff with directions on 3/12/14 at 1:30 p.m. IA)-J and trained medication R25 was last shaved on 6 did not always agree to be				
	3/13/14 at 11:45 a.r expect shaving to b and for the care pla resident refused ca re-approach for car been contacted by s be shaved. SUGGESTED MET The director of nurs ensure that residen activities of daily livi	ing (DON) was interviewed on n. DON stated she would e included in the care plan n to be followed. If the res, she would expect staff to es. DON stated she had not staff related to R25 refusing to HOD OF CORRECTION: ing and or designee could ts who are unable to carry out ng receive the necessary n good nutrition, grooming,				

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	(EACH DEFICIENCY REGULATORY OR L Continued From pa and personal and c	1738 HUL FARIBAU	B. WING		ON LD BE	3/2014 (X5) COMPLETE DATE
(X4) ID PREFIX TAG	JLT CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa and personal and c TIME PERIOD FOI	1738 HUL FARIBAU	ETT AVENUE LT, MN 5502 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa and personal and c	FARIBAU	ID PREFIX TAG	1 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L Continued From pa and personal and c TIME PERIOD FOI	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 35 oral hygiene.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L Continued From pa and personal and c TIME PERIOD FOI	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) uge 35 oral hygiene.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
2 920	and personal and c	oral hygiene.	2 920			
	TIME PERIOD FOI					
	(= .) aaje.	R CORRECTION: Twenty One				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observative review the facility factoria thickened liquids as	ent is not met as evidenced ion, interview and document ailed to ensure the provision of s ordered by the physician for Ə) reviewed with thickened				
	Findings include:					
	R29 was not provid meals.	led thickened liquids during				
	diagnoses that inclu	to the facility in 2011 and had uded diabetes, Alzheimer's, ing to the physician orders				
		on 3/12/14 at 12:20 p.m. Indently. R29 had been				
innesota D TATE FORI	epartment of Health		6899 A ⁻	77C11		n sheet 36 of 7

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00989	B. WING	•		C 1 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, :	STATE, ZIP CODE		
FARIBA	JLT CARE CENTER		ETT AVENU LT, MN 550			
(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)	SHOULD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ige 36	2 965			
1 m 1 m 1 m 1 m	tray were a glass of cup of tea. At 12:3 (TMA)-E placed a s stated the fluids we stated she had not eating. R29 was ob meal on 3/13/14 at regular diet and thir juice, milk, water.) thin. Nursing assis never had thickene started working in th verified on the med R29's liquids were t	et with regular liquids. On the f water, a glass of juice and a 30 p.m. trained medication aide spoon into each glass and re of thin consistency. TMA-E observed R29 to cough while served during the morning 8:15 a.m. R29 was served a n liquids (orange juice, prune TMA-F stated the liquids were tant (NA)-C stated R29 had d liquids since NA-C had he facility a year ago. TMA-F ication administration record to be nectar thick and				
	12/31/13, 2/5/14, 3/ ADA/mechanical so for thin milk on cere therapist recommentary card on the me was to receive nect	rs dated 10/26/13, 11/27/13, (12/14 all ordered Liberal off with nectar thick liquids. Ok eal. On 2/12/13 the speech nded nectar thick liquids. The eal tray identified the resident ar thick liquids. The care area dated 8/5/13 did not identify				
	1/13/14 indicated R assist of one staff, I was on a therapeut speech therapy. Th	num Data Set (MDS) dated 29 was able to eat with limited nad no swallowing disorder, ic diet, and did not have ne dietitian notes of 3/12/14 eceive a liberal ADA diet with		·		
Minnesota D	initiated 6/7/11 and stated R29 had a sy difficulty with regula	plan identified a problem revised on 10/11/13 that wallowing problem related to r food. Coughing or choking allowing medication.				
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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00989	B. WING			C 13/2014
	PROVIDER OR SUPPLIER	1738 HU	ddress, city, s [.] LETT AVENUE JLT, MN 5502 [.]	NORTH		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 965	Interventions dated followed as prescri mechanical soft tex During an interview administrator state were to be thickend an interview on 3/1 stated she was una thickened liquid un note from licensed	4 4/20/13 indicated diet to be bed: liberal diabetic, ktures with thin liquids. on 3/13/14 at 8:33 a.m. the d she was aware the liquids ed and had not been. During 3/14 at 1:00 p.m. cook-C aware of the need for the til today when she received a practical nurse (LPN)-J that	2 965			
	LPN-J was intervie stated that since la	changed to thin liquids. w 3/14/14 at 1:10 p.m. and st August when LPN-J started ty, R29 had not received				
	The director of nurst staff and monitor staff an	THOD OF CORRECTION: sing could review policies, train taff to ensure the provision of s ordered by the physician are ts.	1	•		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21390	Subp. 4. Policies control program mu procedures which p A. surveillance collection to identify residents; B. a system for	0 Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and s of infectious diseases;				

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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: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH** FARIBAULT CARE CENTER FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21390 Continued From page 38 21390 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control: E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the spread of infection during dressing change for 1 of 2 residents (R45) with a gastric tube dressing and tube feeding, failed to ensure isolation precautions were adhered to for 1 of 1 residents (R48) with isolation precautions and failed to assure 1 of 1 residents (R10)Nebulizer equipment was sanitized between use.

R45 had a gastric feeding tube and during dressing change, infection control practices were not implemented to prevent spread of infection.

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Findings include:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 03/13/2014	
		00989				
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		1738 HUI	LETT AVENUE	ENORTH		
FARIBAU	JLT CARE CENTER	FARIBAU	ILT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 39	21390			
	diagnoses (listed fr included: encepha traumatic brain inju dementia with beha	d on 12/26/2013 with om the care plan) that lopathy, dysphagia, history of ry, post traumatic seizures, wioral disturbances, episodic izophrenia, and CVA (stroke).				
	LPN-C went into R4 change around the and removed the du blood tinged draina gloves, the LPN op packaged supplies, handles to the close containing oral toot	s, on 3/11/2014 at 9:20 a.m., 45's room to do a dressing gastric tube. LPN-C gloved ressing which had a tiny bit of ge on it. Without changing ened drawers and touched the resident's chair, door et, a blood pressure cuff, bag hettes, and a mat which was closet. Keeping the same				
	gloves on, the LPN use a Q-tip to clear stoma area. Slight on the Q-tip. LPN-C and feeding syringe snapped the extens checked for patenc	took water from a pitcher and around the gastric tube pinkish drainage was noted then touched the medication and tube extension. LPN-C sion on the gastric tube and y using a stethoscope. When				
	go in. LPN-C had t to listen for patency wearing the same s resident's skin, the She disconnected t into the bathroom to	hister water, the water did not o use the stethoscope again y. At that point, the LPN-C was coiled gloves and touched the stethoscope and the tubing. he extension tube and took it o rinse it out. The LPN -C did				
	reapply the extension Without changing the continued to admini- through the tube us LPN-C was finished did not have gauze She removed the set	ed gloves and continued to on tube to the gastric tube. he soiled gloves, the LPN-C ister water and medication ing the same syringe. After d with the medication task, she to put around the stoma area. biled gloves and went out to to find the gauze. The LPN				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00989	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	JLT CARE CENTER	1738 HUL	ETT AVENU	JE NORTH		
	fan hennen men sen en e		LT, MN 550	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 COMPLETE	
21390	Continued From page 40		21390			
	gloved and put the gauze around the stoma.					
		•				
	On 3/12/2014 at 11	:00 a.m., the director of				
		interviewed regarding lack of				
		bcedures used with R45's the gastric tube site. The				
		rse's should be following				
	standard precautio	ns and also the facility policy				
		es that are not sterile. A policy provided by the facility.				
		g-Non-sterile Treatment reviewed. It identified: "6.				
		clean field. 7. Wash hands. 8.				
e - e - e - e - e - e - e - e - e - e -		11. Remove soiled dressing				
		ag. Remove gloves. Wash ean gloves. 13. Clean wound				
	per physician order	s. Cleanse wound from center				
		sing a circular motion (area of to area of least). Ensure you			-	
		skin surfaces, furniture,				
		eturn to wound bed as this will				
		bund bed. 14. Dispose of bag. 15. Remove gloves and				
	wash hands. 16. A	pply clean gloves. 17. Apply				
	dressing as ordered	d."				
	D40 had rear instant	umothiaillin konistant stank				
		y methicillin resistant staph vith a tracheostomy and				
	infection control pre	ecautions were not consistently				
	implemented.					
	A physician note da	ted 3/5/2014 identified history				
	of present illness: I	Respiratory: Patient with				
		ny and with increased cough and sputum culture showed				
	MRSA and Pseudo	monas and started on IV				
	epartment of Health		6899		······	
STATE FOR	VI		0033	477C11	If continuation sheet 41 of 79	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING			C 03/13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 41	21390			
	antibiotics. Treatm possible pneumoni pseudomonas and					
	closed. A note to c the wall at the door	20 p.m. R48's room door was check at nurse's station was on way. A plastic cupboard at the I gowns, gloves, masks, red pressure cuff and				
	ambulating in the h mask over a trach medication cart wa a.m., R48 was obs with the mask off th	00 a.m. R48 was observed hall with a walker and had a site and then stood at the iting for medications. At 9:00 erved to come out of the room he trach site. A licensed N)-C puts a mask over the		· .		
	trach site and tells because of an infect stated the resident respiratory methicil	the resident it needed to be on ction the resident had. LPN-C was on precautions related to lin resistant staph aureos ved and put a mask on and				
	stated she didn't go didn't spit. She wo in the air and cough was not good about	own because the resident re a mask because of droplets hing from the trach and R48 It leaving a mask on. The resident room and assisted the				
	the mask off the tra bed. At 9:47 a.m., with a mask over th	bathroom. The resident took ach and sat on the edge of the R48 came out of the room he trach and stands by the back DN taughed the resident's				
	walker to redirect th and then without clu to set up medicatio	he LPN touched the resident's he resident away from the cart eansing her hands continued ns. At 10:00 a.m., R48 and threw it on top of a waste				
anacata D	basket on the cart I	but it just laid on top of the plied a new mask and				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY PLETED
		00989	B. WING			C 1 3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		1738 HUL	ETT AVENUE	E NORTH		
FARIDAU	JLT CARE CENTER	FARIBAU	LT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 42	21390			
	continued to set up washing her hands At 2:05 p., R48 ca	the medication without me ambulating out from room				
	The resident's room hall and so the resident	nout a mask over the trach. In is the second door down the dent walks a distance to get to The nurse saw the resident				
n Sale Lik	On 3/11/2014 at 10 nursing station and	:00 a.m., R48 walked into the stood over NA-K who tried to t back to his room since the not covered.				
	with walker at nurse on trach site. At 9:4 ambulating in the h mask on. LPN-C tr	45 a.m., R48 was observed up e's desk, however, had a mask 45 a.m., R48 was observed allway with walker and no ied to redirect the resident, , and continued to set up				
	medication, without resident stood there wear a gown in the gloves because the	washing hands, while the e. LPN-C indicated she didn't room but just a mask and resident didn't cough or spray				1
	everything goes up there. At 10:00 a.m with mask and glov in the container out	during suctioning because the tube and there is no spray n., LPN-C entered the room es on. There were no gowns side the room. The resident is				
	incontinent cloth pa the resident 's feet the resident's foreh	d. The LPN pulled on the d under the resident, moved , touched the linens and then ead. With her gloves still on,				
	changing gloves, Li the resident's trach	with the controls. Without PN-C removed the mask over , touched the dressing around removed the inner cannula				
	and disposed of it in removed the soiled	the wastebasket. Then gloves (had mucous on them) LPN Opened up the new				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
	OF CONTLETION	IDENTIFICATION NOMBER.	A. BUILDING		COMP	LETED
		00989	B. WING	NG 03/13		C 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From pa	ge 43	21390			
21390	With the gloves still neb medication into and started it up an over the trach. She and dated it, poured the resident clothing tube. Went into her then removed the ti extension on the fea- syringe in the tubing stethoscope to chear retrieved 2 cans of in the room, while h without a cap on it r changing gloves, or puts the syringe into tube feeding and giv medications and wa the LPN then unho recapped the syring gloves, she touched the tube feeding ar nebulizer mask and dressing to the tube have any soap in th indicated she had s cart. When checke cart and another sta 3:15 p.m., R48 had	a and put it in the trach site. On, the LPN administered the othe neb mask and extension d placed it on the resident e got out a new feeding syringe d water into a pitcher, touched g and dressing to the feeding r pocket for something and p of the syringe and put an eding tube. She put the g with air in it and takes a ck for placement. The LPN feeding formula out of the box iolding the feeding syringe next to her clothing. Without the feeding syringe, the LPN o the extension tube to the ves the resident the ater flushes. After finishing , oked the extention tube and ge tube. Without changing her d around the stoma skin site of nd then readjusted the parts, then put on a clean e site. The bathroom did not e dispenser. But the LPN anitizer on her medication d, the sanitizer was not on the aff had to retrieve some. At been out at nurse's desk ever the resident did have	21390			
	did not change her throughout the proc					
Minnonata Da	R48's room without	:45 p.m., LPN-J went into putting on a mask and gloves a cloth chux on the resident's				

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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: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH** FARIBAULT CARE CENTER FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21390 Continued From page 44 21390 bed and straightened it out touching linens. The resident had a mask over the trach but was noted to cough. When the LPN-J went into the bathroom to wash her hands she noted there was no soap in the dispenser. She went to the soiled utility room to wash her hands. It was 2 doors down from the resident's room. LPN-J told the housekeeper the resident's bathroom needed soap and the housekeeper went in and filled the dispenser. On 3/12/2014 at 12:49 p.m., a nurse aide (NA)/medical records (MR) (NA)-K/(MR)-K walked into R48's room without a mask, or gloves or gown on. The aide directed the resident into the room and touched the walker and the resident on the back. The resident wanted assistance to get into bed. The aide walked out without washing her hands. NA-F put her gloves on and mask and went in to assist the resident into bed. NA-F was interviewed about the resident and use of a mask over the trach area. She indicated the nurse aides put a mask over the trach when they do cares on the resident . If they see R48 come out of the room, they redirect the resident back to the room and encourage the resident to put a mask on or they do it for the resident. The resident was independent with toileting and washing own hands. On 3/13/2014 at 6:45 a.m., LPN-B was observed in R48's room suctioning the resident. The resident was coughing. LPN-B did not wear a mask but had gloves on. No gowns were available in the cabinet outside the resident's door. At 8:30 a.m., R48 came out to nurse's desk without a mask on and 2 staff (NA-K, LPN-J) walk by the resident for several minutes before redirecting the resident to get a mask on. Minnesota Department of Health

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PRINTED: 03/3
FORM APPR

Minnesota Department of Health STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA (X1) (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER** FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21390 Continued From page 45 21390 On 3/13/2014 at 10:00 a.m., the director of nursing (DON) was interviewed regarding the isolation precautions to be used for R48. She stated masks, gloves, gowns are to be worn when doing cares. R48 was placed on precautions because the resident had a positive culture for MRSA respiratory. Interviewed the DON on observations of poor handwashing and glove exchange, lack of soap in the bathroom, lack of gowns in the cupboard and also discussed observations of resident leaving room without a mask and sometimes being directed and other times not. The DON indicated the staff should be following the precautions because the resident was positive for MRSA and the precautions were set up. On 3/13/2014 at 12 noon, a green droplet precaution sign was placed at the doorway of the resident's room. On 3/13/2013 at 2:00 p.m., R48 walked into the nursing station and stood over RN-A for several minutes until RN-A was able to direct R48 back to his room as the tracheostomy was not covered. On 3/13/2014 at 1:00 p.m., a registered nurse (RN)-A was interviewed, and verified R48 had a problem coming out to the desk area and in the hallways without keeping the trach area covered as directed by facility protocol. On 3/13/2014 at 1:30 p.m., the DON was again interviewed regarding infection control procedures. She stated "[R48], we are unable to keep him in isolation so he is in what we call precaution, but he does not follow through with that either. We are constantly taking him to his Minnesota Department of Health

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Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00989	B. WING		03/1) 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 46	21390			
	room and reapplyin (tracheostomy)."	g the masks to cover the trach				
	NEBULIZER EQUII SANITIZED BETW					
	at 10:15 a.m. to be The nebulizer cup a machine. The nebu	tem was observed on 3/12/14 located on his bed side stand. and tubing was attached to the lizer cup where the medication ad with moisture drops on the				
	that she had set up medication treatme LPN-B had not clea the inhalation treatm	nurse (LPN)-B was /14 at 10:15 a.m. and said and given R10 his nebulizer nt at 8:00 a.m. However, ned the equipment following nent to prevent bacterial th as outlined in the facility				
	was noted to be full there was a white fi the nebulizer cup. C and care of the neb R10 said, "They [re- ever clean it." R10 s	1/17 p.m. R10's nebulizer y connected and this time Im coating the entire inside of on asking R10 about the use ulizer equipment at this time ferring to facility staff] don't said that he had used the t earlier in the day and no one e then.				
Ainneseta Di	assistant (TMA)-A v cleaning of R10's no the inhalation treatm equipment is to be t	p.m. trained medication vas asked about the use and ebulizer equipment following nent. TMA-A said that the aken apart and the cup is to nd the equipment is to air dry.				

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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: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER** FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21390 Continued From page 47 21390 However, this had not been done following R10's inhalation treatment on 3/12/14 8:00 a.m. dose nor on 3/13/14 after 8:00 a.m. dose. The director of nursing was made aware of lack of following the facility policy on the care of the nebulizer equipment on 3/13/14 at 2:47 p.m. and she was also asked for the policy in regards to the nebulizer inhalation procedure. Facility policy Desert Health Group Small Volume Nebulizer Procedures, revised date 06/2013 read. "11. Administer therapy until the medication is depleted (about 10-15 minutes)." and "13. Disassemble device and rinse the mouthpiece and nebulizer cup with water and dry. Store unit per facility policy. Dispose of equipment per facility policy." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are current, that staff are trained and monitored to assure procedures are implemented to prevent the spread of infection when caring for residents. TIME PERIOD FOR CORRECTION: Twenty One (21) days. 21510 MN Rule 4658.1200 Subp. 2 A.B. 21510 SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
				··		С
		00989	B. WING	·		13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
FARIBA	JLT CARE CENTER		LETT AVENU JLT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21510	Continued From pa	age 48	21510			
	required services fr according to part 4	om an outside source 658.0075.				
	by:	ent is not met as evidenced				
	facility failed to prov	and document review the vide rehabilitative services as 1 resident (R46) reviewed.				
	Findings include:					
	R46 lacked a referr	al for rehabilitation services.				
	hospital to the facili R46's diagnoses lis screening dated 11 (alcohol induced de The care plan print diagnoses as alcoh	on 11/5/13 from an acute care ty's locked dementia unit. sted on the preadmission /5/13 at Karsakoff dementia ementia) and bipolar disease. ed 2/18/14 identified R46's iol induced dementia, bipolar ependence, drunkenness, vatitis.				
	11/12/13 and the quindicated R46 had a status (BIMS) score impairment, display	imum Data Set (MDS) dated uarterly MDS dated 1/12/14 a brief interview for mental e of 13/15 or no cognitive red no behaviors, was ctivities of independent living.				
	stated was admitted abuse and had not program. R46 state outpatient services community, but had	on 3/10/14 at 5:13 p.m. R46 d with a diagnosis of alcohol been involved in a treatment ed he had investigated found some available in this not been provided access to he would be willing to do ent treatment.				
Minnosota		e summary dated 11/25/13				
STATE FORM	epartment of Health VI		6899	477C11	If continuatio	n sheet 49 of 79

Minnesota	Department	of Health

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED C
	00989	B. WING			1 <u>3/2014</u>
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
JLT CARE CENTER					
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
noted, "Resident w facility or a facility w The care plan printe resident's history w treatment was not r During an interview director of nursing (social services was	ould like to be in a treatment where people are younger." ed 2/18/14 was reviewed. The th alcohol and request for noted. on 3/13/14 at 12:10 p.m. the DON) stated she thought	21510			
interviewed on 3/13 R46 had discussed treatment as outpat she had contacted guardian did not wa because guardian w able to return to the she had also discus case manager and needed to get the g the management te not hold the bed for inpatient treatment if a readmission beau stated she had not outpatient treatment	/14 at 12:57 p.m. SSD stated with her the request of ient or inpatient. SSD stated the guardian. SSD stated the int R46 to go to treatment vas afraid R46 would not be nursing home. SSD stated seed treatment with the county that he had said the facility uardian on board. SSD stated am stated the facility would return following the 90-day program so SSD did not know d would be available. SSD investigated further for t. SSD stated she was unable				
previous social work programs. SUGGESTED MET The director of nurs monitor to assure th	ker related to treatment HOD OF CORRECTION: ing and or designee could nat residents are assessed				
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SSD stated the guardian did not want R46 to go to treatment because guardian was afraid R46 would not be able to return to the nursing home. SSD stated she had also discussed treatment with the county case manager and that he had said the facility needed to get the guardian on board. SSD stated the management team stated the facility would not hold the bed for return following the 90-day inpatient treatment program so SSD did not know if a readmission bed would be available. SSD stated she had not investigated further for outpatient treatment. SSD stated she was unable to find any social services documentation from previous social worker related to treatment programs. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could monitor to assure that residents are assessed and referred to	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00989 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST PARCHARCE CENTER 1738 HULETT AVENUE FARIBAULT, MN 5502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 49 21510 noted, "Resident would like to be in a treatment facility or a facility where people are younger." The care plan printed 2/18/14 was reviewed. The resident's history with alcohol and request for treatment was not noted. The social services was working on the treatment issues. The social service designee (SSD) was interviewed on 3/13/14 at 12:10 p.m. the director of nursing (DON) stated she thought social services was working on the treatment issues. SSD stated R46 had discussed with her the request of treatment as outpatient or inpatient. SSD stated she had contacted the guardian. SSD stated the manager and that he had said the facility needed to get the guardian on board. SSD stated she had also discussed treatment with the county case manager and that he had said the facility uncated the dad for return following the 90-day inpatient treatment program so SSD did not know if a readmission bed would be available. SSD stated she had not investigated further for outpatient treatment. SSD stated the was unable to find any social services documentation from previous social worker related to treatment programs. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could monitor to assure that residents are assessed and referred to appropriate rehab	OF CORRECTION IDENTIFICATION NUMBER: 00989 A BUILDING: B. 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	(21) days.					
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	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 resided adversely affected, matter to the medical director is a the medical director is a the medical director is a the medical director physician does not the order and if the change the order, ti review to the Qualit (QAA) committee re-	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on observati review, the facility f for use and failed to as needed psycho-	ent is not met as evidenced on, interview, and document ailed to develop parameters o monitor the effectiveness of active medications for 2 of 5 0) reviewed for unnecessary				
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Minnesota Department of Health

A BUILDING: A BUILDING: C 00989 B. WING 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CTV, STATE, ZP CODE 03/13/2014 FARIBAULT CARE CENTER 1/28 HULLET T VENUE ON ORTH FARIBAULT, MIN SO21 PREMY EVALUT PREPARATION DE DEFINITIVING INFORMATION PREMY CROSERFEE STULL STULL 7700 EVALUATION ON LSC DENTIFYING INFORMATION PREMY CROSERFEE STULL STULL TO VENUE STULL TO PREVACE TO THE APPROPRIATE DOWE THE CONSTRUCT STULL TO PREVACE TO THE APPROPRIATE DEFICIENCY 21540 Continued From page 51 21540 21540 Continued From page 51 21540 R27 was on an anti-anxiety medication without parameters for use, documentation of of effectiveness when used, and without use of non-pharmacological Interventions; and was on multiple scheduled psychotropic maticalications without adequate monitoring . R27 was admitted to the facility 2/3/2014 with dx (from care pian) altered mental status, traumatic amputation of toes, sedative/hyponici anxio/ytic dependence, nondependent cannabis abuse, diabetes, hypertension, esophageal rellux, opoid type dependence abuse, dissociative identify that addition with hall(citations, parameter) solutase, desociations were altered to several time in both months. The scheduled other psychotropic medications were given as ordered. The target behaviors that were identified to be monitored included mood indicators, behavior indicators, behavior indicators, behavior indicators, behavior indicators, behavior medication severel documented on		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
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T328 HULET AVENUE NORTH FARIBAULT, MN 5532 Image: Colspan="2">PROVIDER'S PLAN OF CORRECTION (ESCONDERICENCYMUST BE PRECEDED BY FLUL PRETIX PREFIX (ESCONDERICENCYMUST BE PRECEDED BY FLUL PREFIX PREFIX (ESCONDERICENCYMUST BY FLUX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PRE			00989	B. WING		03/1	3/2014
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	/innesota D	monitored included indicators, hearing objects not there, a direction, and pacin documented on ever analysis of the beha data to identify effect needed antianxiety psychotropic medic Elavil, Trilafon).	mood indicators, behavior voices not there, seeing gitation-not responding to ng. These behaviors were ery shift daily. However, an aviors was not compiled of the ctiveness of the use of the as medication and other multiple				
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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: _ С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER** FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 21540 Continued From page 52 21540 R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The use of the as necessary and scheduled psychotropic medications with interventions was not addressed. On 3/13/2014 at 12:50 p.m., the DON was interviewed regarding use of prn antianxiety medication. DON stated staff should be documenting in the MAR and follow up for effectiveness. They are to attempt non pharmacological interventions prior to the prn use. The documentation was not evident in the MAR or record and the DON verified that. On 3/13/2014 at 12:50 p.m., and 3:00 p.m., the DON was interviewed regarding a summary/analysis of the behavioral data to identify effectiveness of the scheduled medication and use of the as needed antianxiety medication. She indicated no analysis was done of the behavioral data. No criteria for the use of the as needed medication was provided. R40 used as needed antianxiety medication for sleep and anxiety without criteria for use. monitoring of effectiveness and lack of use of non-pharmacological interventions prior to administration. A Discharge summary from the hospital dated 1/9/2014 identified R40 used as needed Lorazepam for anxiety and every bedtime for sleep as needed. Admitted 1/11/2014 with diagnoses hx of falls, schizoactive disorder, paralysis agitans, compression of brain, parkinson's disease, hx of Minnesota Department of Health

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
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21540	Continued From pa	ge 53	21540			
		rebral hemmorrhage, phalus, insomnia. (on MD				
	Lorazepam 0.5 mg needed for anxiety;	ated 1/16/2014 identified by mouth every 6 hours as and Lorazepam 0.5 mg (4 outh at bedtime as needed for				
	Lorazepam (antian: necessary for sleep	dication sheets were reviewed: kiety medication) was used as and/or anxiety: 1/149 ed 23 times and in 3/14-it				
i . 	reviewed. It identifie staying asleep; rela history of taking sle to bedtime. An aver hours. R40 had ne Parkinson's disease environmental factor sleeping difficulties assessment was a	dated 1/13/2014 was ed the resident had difficulty ted to pain; did not have a ep medications routinely prior rage length of nap was 1-2 urological deficits (stroke, e, seizure disorder). No ors contributing to resident was identified. The collection of data but did not or analysis of the data to				
	and print out date o	h initiated date of 1/14/2014 f 2/20/2014 was reviewed. It D's sleep issues or use of as medications with				
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Minnosota	assistant (TMA)-C	45 a.m., a trained medical was interviewed regarding use edication. TMA-C indicated				
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21540	and indicated R40 night for sleep. The rarely used it throug resident was up and	ge 54 e medication during the day was given the medication at e resident got anxious but ghout the day because the d about. The TMA did not riteria to use prior to giving the	21540			
	DON was interview antianxiety medicat be using non pharm to administering the following up also fo indicated she just d 2/17/2014. She als monitoring and indi DON verified they of	:50 p.m. and 1:05 p.m., the ed regarding criteria for use of ion. DON stated they should nacological interventions prior e medication and should be r effectiveness. The DON id an education on that on to checked for R40 re: sleep cated it was not being done. lid not analyze the sleep o come up with a plan.		· · · · · · · · · · · · · · · · · · ·		
1 1 m	The director of nurs assure that policies and that staff trainin assure each reside	HOD OF CORRECTION: sing and or designee could and procedures are updated ng has been completed to ent's drug regimen is residents are not taking				
21685	(21) days. MN Rule 4658.1418 Housekeeping, Ope Subp. 2. Physical p	R CORRECTION: Twenty One 5 Subp. 2 Plant eration, & Maintenance plant. The physical plant, rs, ceilings, all furnishings,	21685			

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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: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER** FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21685 Continued From page 55 21685 systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to keep kitchen equipment and the kitchen environment clean and sanitary, also failed to keep the physical environment free from foul odors. Finding include: During the kitchen tour with Cook-A and Cook-B on 3/10/14 at 1:45 p.m. the following was observed: Upright freezers and refrigerators located in the kitchen had a thick layer of dust covering the grill and when the grill was moved the dust covered the entire top of the pieced of equipment. The ice machine located in the dining room was observed to have the grill covered with a thick coat of dust/debris and the reusable filter was coated with white powder type debris. The floor in the kitchen had multiple food debris scattered around the perimeter of the room. The electrical cords and water tubing connected to the appliances including the coffee maker was coated with a thick layer of dust/debris. The metal emergency pull ring located near the coffee machine had long strands of dust/debris. During the environmental tour on 3/13/14 at 8:30 a.m. accompanied by the director of maintenance Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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- <u>N</u>	00989 B. WING				03/1	3/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE	
21685	Continued From pa	age 56	21685				
	·	per. The following was					
	odor present and the odor continued housekeeper said it	t sometimes smells and they nroom. However, the urine					
	equipment includin resident lifts lined of hallway. Also the m	observed to have resident use g wheel chair, weight chair, lown the west side of the nedication cart is placed on the Ilway. There were two				,	
	opposite directions into an open door v pass them by. With used to store reside who are ambulator	each other going in the and one of them had to move vay to allow the other resident the west side of the hallway ent equipment the residents y do not have free access to be west side to the hallway. On					
	asking the mainten housekeeper it was the west side of the equipment because the area to keep th the maintenance di this practice of kee						
	a long time.						
	The director of nurs and/or designee co including walls, floc systems, and equip state of good repair	HOD OF CORRECTION: sing, director of maintenence uld assure the physical plant, ors, ceilings, all furnishings, ment is kept in a continuous r and operation with regard to safety, and well-being of the				ر م بر مع بر	

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Minnesc	ota Department of He	ealth			1 OT IM	AFFNOVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		00989	B. WING		03/1) 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENU			
(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 APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	Continued From pa	age 57	21685			
	residents according maintenance and r	g to a written routine epair program.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			
	residents shall have medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve their vsical and mental functioning. where the service is not iblic or private resources.				
e more e e e construction de la construction de la	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure the use of aides for 1 of 2 residents (R4) ing aides.				
	7:00 p.m. R4 was of able to hear despite present in the left e the missing hearing not know what the f or replacing the hear NA-B came into the	and interview on 3/10/14, at complaining about not being e having a hearing aide var. R4 said she had reported g aide to her right ear, but did facility was doing about finding aring aide. Nursing assistant e room and when questioned happened to the hearing aide				

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Minneso	ta Department of He	alth			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00989	B. WING		C 03/13/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
FARIBAU	JLT CARE CENTER		ETT AVENU		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21810	Continued From pa	ige 58	21810		
	When asked how d shrugged shoulders work, I'm used to h attempted to chang could not hear the d	he left ear was not working. lo you communicate NA-B s and stated, "We make it er." The nursing assistant le the battery for R4 but R4 conversation which surveyor mputer for R4 to read and			
	R4 was on her way not have her hearin designee (SSD) wa hearing aides and o concern form and v aide was missing. A found the hearing a	ion on 3/13/14, at 11:50 a.m., to the beauty shop and did ig aides in. The social service is questioned about the did not have a missing item or vas not aware the right hearing About 1 p.m. the SSD said she ides in the medication cart 's ears and she can hear now, st fine.			
	is not the new one, are my old hearing not able to hear sur verified she did not	s interviewed and stated, "This (pointing to right ear) these aides that don't work." R4 was veyor. Interview with RN-A know the hearing aide was at R4 had the hearing aide last			
	(MDS) form dated ⁻ to cerebral vascular attack, thyroid disea ears.	is from the minimum Data Set 2/29/13, lists but is not limited r accident, transient ischemic ase, and hearing loss both			
	dated 12/30/13, ind	for Mental Status (BIMS) icated a summary score of 9 i for cognitive patterns impairment.			
Ainnosota Da		ated 12/3/13, directed staff, "I			
/iiinnesota De	epartment of Health				

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Minnesc	ta Department of He	ealth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		00989	B. WING			C I 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY, S	STATE, ZIP CODE		
			ETT AVENU			
FARIBAU	JLT CARE CENTER		LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	ige 59	21810			
	of hearing. Make ce aides prior to the st Furthermore, the pl read, "I have exten impaired communic impairment." The i hearing aids left in taken to the nurses educated me on the keeping them locket theft policies of the aids. I can put them independently. I will especially with takin on the plan of care again attempted to aides kept in nurse Resident rejected t losing hearing aide anything from resid	lan of care revised 7/10/13, sive hearing loss. Potential for				
	7/16/13, under recc plan from nursing h hearing aids will be with replacement. F aide fitting." The co audiology dated 9/3 wearing both aides batteries weekly, ea size 13 or orange a blue). 3. Turn heari opening battery doo hearing aide reched problems." A docum and dated 10/4/13, had a size 13 batte	port from audiology dated ommendations read, "Need oome of how future loss of prevented before patient is fit Return in 2 weeks for a hearing nsultation report from 8/13, read "1. Continue daily. 2. Replacing both arly if needed (the left uses the nd right uses size 675 or ng aids off when not in use by ors. 4. Return in 4 months for a ck, sooner if there are nent titled Audiology office visit read "The right hearing aide ry in it instead of the 675. The on both hearing aides. The				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		00989	B. WING		03/1	C 3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU			
(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 APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 60	21810			
		aced in both hearing aids. The d. Both hearing aides are				
	for March 2014, the the tracking of the t	dication and treatment sheets are was no area addressing bilateral hearing aides. The ssignment sheet read,				
	size for which ear, r	t did not designate the battery nor did the assignment sheet int for the hearing aides.				
	unsuccessful to dis the medical record family was difficult t answering machine	resident family were cuss the hearing aides and director (MRD) validated the o get hold of as neither had s or message capabilities. how if the family was aware of de being missing.				
	The facility could as are updated, impler and that based on i personal care base provided to enable	HOD OF CORRECTION: ssure that policies, procedures nented, evaluated, monitored ndividual assessments, d on individual needs is residents to achieve their sical and mental functioning				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21855	MN St. Statute 144. Residents of HC Fa	651 Subd. 15 Patients & c.Bill of Rights	21855			
	residents shall have	nent privacy. Patients and the right to respectfulness ates to their medical and				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	·	00989	B. WING		C 03/13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	
FARIBAU	JLT CARE CENTER		LETT AVENU JLT, MN 5502		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 COMPLETE
21855	Continued From pa	ige 61	21855		
	consultation, exami confidential and sha Privacy shall be res bathing, and other	ram. Case discussion, ination, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene, or patient or resident safety or			
	by: Based on observati review the facility fa privacy during care observed for incont	ent is not met as evidenced ion, interview and document ailed to ensure personal s for 1 of 3 residents (R25) inence and the facility failed to bersonal information for 1 of 4 served smoking.			
	Findings include:				
8. ^{- 1}	R25 lacked privacy	during incontinence cares.			
		on 3/11/14 at 9:12 a.m. R25 pull curtains or close doors to ing cares.			
	provided by nursing medication aide (TI 1:30 p.m. and 1:50 was observed to ur TMA-E was observ the room without pu providing personal in bed exposed. TM again. No privacy of personal privacy was				
	the privacy curtain s	ewed at 1:50 p.m. and stated should have been pulled			
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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00989	B. WING		03/1	; 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FARIBA	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(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) COMPLETE DATE
21855	Continued From pa	ige 62	21855			
	before she exited th	ne room.				
		on 3/13/14 at 11:45 a.m. the stated privacy was an				
Ng	R46 lacked confide information.	ntiality of personal smoking				
	posted in the nursir activity area that sta typing] Smoking Sc	p.m. a sign was observed ng area/dining room/resident ated [R46's name in bold hedule. The sign listed the cigarettes R46 could smoke				
		on 3/10/14 at 5:11 p.m. R46 s were locked up and felt way.				
	3/13/14 at 7:35 a.m	on 3/12/14 at 7:10 p.m., on a. outside to smoke under staff time R46 was observed to ask moke.				
	completed a smoki stated the resident cognitive loss, and in bedroom or bath risk assessment da smoking, "will jump	nts identified the facility ng assessment on 2/6/14 that required supervision, had had been observed smoking room. The facility elopement tted 2/6/14 noted under o fence if given a chance". No sis of data was provided.				
Minnosota	focus related to sm directed the resider	plan printed, 2/18/14, had a oking The interventions nt required visual supervision cigarettes and lighter were to				
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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BOILDING.			C
		00989	B. WING			3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		LETT AVENUE ILT, MN 5502			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		(VE)
PREFIX	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 63	21855			
	director of nursing (R46 had smoking is schedule had been had wanted to go o and needed superv risk. DON stated th	on 3/13/14 at 12:10 p.m. the DON) stated she was aware ssues and that a smoking implemented because R46 utside to smoke frequently ision because of elopement the posting of the smoking area was a dignity issue.				
	The facility could as procedures are revi conducted to assur- privacy during cares information regardir	HOD OF CORRECTION: soure that policies and ewed and that staff training is e residents have personal s and that personal ng the resident is kept posted for everyone to see.				
	TIME PERIOD FOF (21) days.	CORRECTION: Twenty One				
21880	MN St. Statute 144. Residents of HC Fa	651 Subd. 20 Patients & c.Bill of Rights	21880			
	shall be encouraged their stay in a facility to understand and a patients, residents, residents may voice changes in policies and others of their of interference, coercie including threat of d grievance procedure well as addresses a	aces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, ischarge. Notice of the e of the facility or program, as nd telephone numbers for the cility Complaints and the area				

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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: С B. WING 00989 03/13/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER** FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21880 Continued From page 64 21880 nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances related to answering of the call lights for 6 of the 43 residents (R12, R2, R31, R53, R58, R28) who resided in the facility who expressed concern with

Findings include:

call lights being answered.

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMI	PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
FARIBA	ULT CARE CENTER	1738 HUL	ETT AVENU LT, MN 550	ENORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21880	Continued From pa	ge 65	21880		- 	
	R12 stated, during at 5:00 p.m., "I think respect and dignity here." When asked "I have heard the st and I have complain treated, but they do the resident council about the problems the staff are verball talked about anothe call light on and it w by the doorway and was trying to get the "Not now! Better be oxygen hose becau referred to the staff what do you want? yourself! R12 referr defensive with her b on the name tags. If situations to the resise should be criteria in have talked to and a They don't follow th confident staff are p Review of R12's Bri (BIMS) dated 12/11 score of 13 out of a patterns indicating of The resident counci- reviewed and docum (1) 3/6/14, several of were brought up su- coming into the root then leave and don	an initial interview on 3/10/14, k they need better training in which I consider to be abusive to further explain R12 stated, taff yell at the lady next door ned myself about how I was in't believe me here. Look at I minutes, we keep telling them but they don't follow through, y abusive and rude." R12 er situation when she had the vas taking awhile so she stood I two staff walked by as R12 eir attention one of them said careful, I will cut off your ise I know how to do it." R12 making comments like, Yeh, You should be able to do it red to the staff as getting but she cannot see the names R12 said she had reported sident council, and there in place so you know who you so people will follow through. rough and R12 is not bassing on the information. ief Interview for Mental Status /13, indicated a summary possible 15 for cognitive cognitively intact. il meeting minutes were mentation included: concerns regarding call lights ch as R12 expressing staff m, whip off the call light and				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	•				С
		00989	B. WING		03/13/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
FARIBAU	JLT CARE CENTER		ETT AVENUI LT, MN 5502		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
21880	Continued From pa	ge 66	21880		
	have someone else happens more than on for a half hour to R31 said, call lights the evening.	ay they will be back, they to take care of, and this once, I can have my call light an hour. are generally worse during about having to wait on the			
	(2) 2/6/14, concerns meal times and call according to R2, R1	s were expressed regarding lights continue to be an issue 2 and R31.			
· · · · · · · · · · · · · · · · · · ·	response time R31 answered, so few,(t minutes. Meal times answer lights. R53 agreed and co hour. R13 expressed Stat	en asked about the call light expressed, will they ever be wo) people working, takes 40 s there is no one around to mmented Yes, takes half an if needs to slow down, they ogether and get out of there, more time		•	
	to forty five mnutes R28 referred to issu p.m. R12 referred to a re the bell, she didn't h R31 said half the tin assistants) are not n TMA (trained medic	,			
Minnoroto Do	concerns recommer resident council me	lacking to indicate the ndations expressed during the etings had been acted upon the residents to assure the n remedied.			

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STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
		00989	B. WING		(03/1	C 3/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S ETT AVENUE	TATE, ZIP CODE		
FARIBAU	ILT CARE CENTER		_T, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLETE DATE
tinneeste D	activity director (AD residents concerns meetings are to be form by the departr be the director of m although all staff we resident call lights. minutes on to the d to process a grieva attended the Decer council meetings an were being conduc response times, an staff. The DON did March resident coucer answered timely by were ongoing and a staff regarding answ verified the residen serious concern with lights and were bed because answering concern for many n During an interview R2 regarding reside expressed at reside my light on and the evening shift. They they rush along and sick of it." R2 further being brought up at "It constantly contin get by with this, I ha told there is no one my pants two mont come. Now I have I	3/13/14, at 9:15 a.m. with the b) it was confirmed that expressed at resident council documented on a grievance nent involved. Call lights would ursing (DON)responsibility ere responsible to answer The AD passes the meeting epartment heads and they are nce form. The DON had nber and January resident nd informed residents audits ted of the resident call light d that a memo was posted to not attend the February and ncil meetings but answered ns of the call lights not being referring to the audits that a memo being posted to the wering call lights. The AD ts continiued to express th the answering of the call coming increasingly frustrated of the call lights has been a	21880			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00989	B. WING		C 03/13/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	03/13/2014
FARIBAU	JLT CARE CENTER		LETT AVENUI JLT, MN 5502		
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
21880	Continued From pa	age 68	21880		
	what is happening	with my complaints."			
497. 197	Mental Status (BIN summary score of	pf R2's Brief Interview for IS) dated 1/20/14, indicated a 15 out of a possible 15 for ndicating cognitively intact.			
	administrator was u documentation to v concerns expresse follow up discussed	on 3/13/14, at 1:30 p.m. the unable to produce any validate the resident specific of were investigated and/or a d to their satisfaction with the nistrator stated, "We have e process."			
	The director of nurs assure residents g	THOD OF CORRECTION: sing and or designee could rievances are listened to, actec Its are reported back to the	8		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One			
21990	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4 Reporting - Inerable Adults	21990		
	immediately make entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify t caregiver, the natu	ng. A mandated reporter shall an oral report to the common a telecommunications device or similar device shall be report. The common entry ire written reports. To the e report must be of sufficient he vulnerable adult, the re and extent of the suspected evidence of previous			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	00989	B. WING			C 13/2014	
PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
JLT CARE CENTER						
		JLT, MN 5502				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Continued From pa	uge 69	21990				
reporter, the time, of incident, and any of reporter believes m the suspected malt reporter may disclo in section 13.02, an	date, and location of the ther information that the ight be helpful in investigating reatment. A mandated se not public data, as defined ind medical records under					
by: Based on observati	on, interview and document					
and immediately re 6 of 8 residents (R1 the sample who rep addition, the facility residents were prot	ported to the state agency for 2, R1, R70, R16, R59, R63) in ported allegations of abuse. In failed to ensure these ected from potential retaliation					
Findings include:						
allegation of potent to thoroughly invest the resident from po investigation was po	al abuse and the facility failed tigate the allegation, protect otential abuse while an ending and immediately report					
3/10/14, at 5:00 p.m need better training consider to be abus further explain R12 yell at the lady next myself about how I believe me here. Lo	n., R12 stated, "I think they in respect and dignity which I sive here." When asked to stated, "I have heard the staff door and I have complained was treated, but they don't bok at the resident council		•			
	PROVIDER OR SUPPLIER JLT CARE CENTER JLT CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa maltreatment, the r reporter, the time, o incident, and any or reporter believes m the suspected malt reporter may disclo in section 13.02, ar section 144.335, to comply with this su This MN Requirem by: Based on observati review the facility fa of potential abuse v and immediately re 6 of 8 residents (R1 the sample who rep addition, the facility residents were prot while an investigation Findings include: R12, R1, R70, R16 allegation of potent to thoroughly invest the resident from poinvestigation was potent the allegation to the R12, during an initia 3/10/14, at 5:00 p.m need better training consider to be abus further explain R12 yell at the lady next myself about how I believe me here. Lo	OF CORRECTION IDENTIFICATION NUMBER: 00989 00989 PROVIDER OR SUPPLIER STREET AI JLT CARE CENTER 1738 HUI FARIBAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63) in the sample who reported allegations of abuse. In addition, the facility failed to ensure these residents were protected from potential retaliation while an investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse and the facility failed to thoroughly investigate the allegation, protect the resident from potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, during an initial observation and interview on 3/10/14, at 5:00 p.m., R12 stated, "I think they need better training in respect and dignity which I consider to be abusive here."	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00989 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S JLT CARE CENTER 1738 HULETT AVENUL FARIBAULT, MN 5502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 69 21990 maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63 neothed an allegation of potential abuse and the facility failed to thoroughly investigate the allegations, protect the facility failed to ensure these residents were protected from potential retaliation while an investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, during an initial observation and interview on 3/10/14, at 5:00 p.m., R12 stated, "I think they need better training in respect	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00989 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE JLT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCES REQUATORY OR LSC IDENTIFYING INFORMATION ID PREVIDER'S PLAN GET (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDER'S PLAN GET (EACH ORRECTIVE ACT CROSS REFERENCE TO TO DEFICIENCY COntinued From page 69 21990 maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter balieves wight be helpful in investigating the suspected maltreatment. A mandated reporter balieves wight be needed by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were thoroughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63) in the sample whor eported allegations of abuse. In addition, the facility failed to ensure these residents were protected from potential retailation while an investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, R1, R70, R16, R59, R53 reported an allogation of potential abuse while an investigation was pending and immediately report the allegation to the state agencies. R12, during an initial observation and interview on 3/10/14, at 5:00 p.m	OF CORRECTION IDENTIFICATION NUMBER: 00989 A. BUILDING: UNING COME PROVIDER OR SUPPLER STREET ADDRESS, GTY, STATE, ZIP CODE 037 PROVIDER OR SUPPLER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 PROVIDER'S PLAN OF CORRECTIVE AUTION NUMBER: (ACH CORRECTIVE AUTION NUMST BE PRECEDED BY FULL REGULATORY ON LSD DENTIFING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE AUTION OF OUND BE CACH CORRECTIVE AUTION OF OULD BE CACH CORRECTIVE AUTION OF OULD BE CONSS REFERENCE TO THE APPROPRIATE DEFICIENCY Continued From page 69 21990 Mailreatment, the name and address of the reporter had visclose not public data, as defined in section 13.023, to the extent necessary to comply with this subdivision. 21990 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all allegations of potential abuse were throughly investigated and immediately reported to the state agency for 6 of 8 residents (R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse and the facility failed to thoroughly investigated and and investigation was pending. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation of potential abuse and the facility failed to thoroughly investigated and and investigation was pending and immediately report the resident from potential abuse and the facility failed to thoroughly investigated and allegation to the state agencies. Findings include: R12, R1, R70, R16, R59, R63 reported an allegation to the state agencies. Findings include: R12, during an initial observation and interview on 310/14, at 5:00 p.m.,	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
		00989	B. WING		C 03/13/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1738 HUL	ETT AVENU	E NORTH		
FARIBAU	JLT CARE CENTER	FARIBAU	LT, MN 5502	21		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21990	Continued From pa	ge 70	21990			
	abusive and rude." situation when she taking awhile so sh two staff walked by attention one of the careful, I will cut off know how to do it."	v through, the staff are verbally R12 talked about another had the call light on and it was e stood by the doorway and as R12 was trying to get their m said "Not now! Better be your oxygen hose because I R12 referred to the staff like, "Yah, what do you want?				
	You should be able to the staff as gettir cannot see the nan said she had report council, and there s you know who you will follow through.	to do it yourself!" R12 referred ng defensive with her but she nes on the name tags. R12 red situations to the resident should be criteria in place so have talked to and so people They don't follow through and ng confident staff are passing				
	dated 12/11/13, ind	w for Mental Status (BIMS) icated a summary score of 13 for cognitive patterns ly intact.				
	December 2013 un read "Don't appreci (certified nursing as	dent council minutes from der the section "Old Business" ate the evening CNA's ssistant) coming in saying they " This concern was addressed w of the form tilled				
	"Resident/Family G R12's statement re when asked, are yo and respect, she re was told, I have 30 any grief." R12 did it was in the evenin	rievance/Concern Form" for ad, "During resident council bu being treated with dignity sponded Not always and said patients today, don't give me not know who it was, only that g and it was a CNA. Reported (7/13. The administrator wrote				
Minnesota De		e interviewed two nursing both denied the allegation.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00989	B. WING		03/1) 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 550			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21990	Continued From pa	ige 71	21990			
	The facility was una documentation, inv regarding R12's gri	estigation or staff education				
		/20/13, indicated a summary possible 15 for cognitive severe impairment.				
	minutes, the quest you are treated with was quotes, "Some	ember resident council meeting ion was asked, Do you feel n dignity and respect and R1 e of them, evening doesn't help ial observation and interview				
	on 3/11/14, at 2:09 here abused you R stated, "Verbal abu yelled at for needin	p.m. when asked has anyone 1 stated Yes and further se has happened, I have been g help and have asked about it ncil." R1 is not aware of the				20
	disposition for her of continues to have of	complaint and validated she concerns for abuse and stated, et upset with me and will scold				
		estigation or staff education vance expressed from the				
	3/11/14 ,at 1:29 p.n R70 stated, "I have	al observation and interview on 1. when asked about abuse heard the staff bark at ay, I was just in here, what do				
	informed and he ha that people get yell	d that administration has been is told "The powers that be, ed at or scolded here." R70 fooling that regidente are				
		a feeling that residents are anded for asking for things				
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Minnesc	ta Department of He	alth			I OI IWI F	AFFNOVED
				(X3) DATE SURVEY COMPLETED		
	00989 B. WING				C 03/13	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ULETT AVENU			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 72	21990			
	R70 mentioned the him have been vert stated, "people are to ask to go to the b	he residents are "Shunned!" ladies across the hall from bally abused from the staff an in pain here, people are afrai bathroom because they will ge ard it and reported it."	d			
	score of 14 out of a patterns indicating		,			
a '		able to produce any grivance intation, investigation or g R70's grievance.				
	reviewing a form titl Grievance/Concern "Resident asked for Stated 'everyone al feel like a drug reha out the cards and le Resident showed h this it would hurt. SI problems." The Res by facility staff mem concerns with staff	dated 2/18/14, by R59 read, r his pills staff went off on him ways wants these pain pills. I ab. Then said I should just ge et them just take them.' is stomach and said if you ha he stated I've had worse sponse /Internal investigation ober read, "Reviewed involved and did staff g verbalizing frustration and	t			

When interviewed on 3/13/14, at 1:15 p.m., R59 verified the staff member was disrespectful and did not want to have anymore conversation about the situation.

R59's BIMS dated 2/19/4, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating cognitively intact.

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Minnesc	ota Department of He	alth			1 0110	IN THOVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FARIBA	JLT CARE CENTER		ETT AVENU LT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21990	Continued From pa	.ge 73	21990			
	The facility was una documentation, inve regarding R59's grie	estigation or staff education				
	council meeting No week in the evening lady came into his r	rievance during a resident vember 2012, and read, "Last g he was in bed and a Chinese oom and twisted his leg. give day or time this				
	happened. The inter read, the writer calle to residents legs be moved his legs, but	ernal investigation in summary ed staff at home, who referred ing tangled in the sheet, the refused to get up, brief ged him in bed by moving his	2			
	score of 12 out of a	25/13, indicated a summary possible 15 for cognitive noderate impairment.				
	The facility was una documentation, inve regarding R16's grie	estigation or staff education				
	problem with [NA-Z] to me, she said, 'I s everyday,' It was he thought the incident requested care and The response to the	e concern which read, "Had a], She was rude and abusive houldn't have to do this er tone, terrible attitude." R63 t was at night on Sunday. R63 the staff member did nothing. e grievance read, "Talked to remember being this way, factual."				
		/12/13, indicated a summary possible 15 for cognitive cognitively intact.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00989	B. WING		C 03/13/2014		
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/1	13/2014	
			.ETT AVENU				
FARIBAU	JLT CARE CENTER	FARIBAU	LT, MN 5502	21			
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21990	documentation, inv regarding R63's gri A review of the faci "Abuse Prevention read, "Interview the witnesses. Witness (1) witnessed or he close contact with t incident {including of members}; and (3) closely with the acc alleged victim the of written statements the accused, and e policy defines verba written or gestured disparaging and de During an interview administrator was u documentation from the protection, inve on abuse related to R12, R1, R70, R59 don't know why the abuse." The admin were dealt with but documentation to c complaints. The ad resident complaints should have been r The administrator w have been protected verbal abuse and th not implemented for	able to produce any estigation or staff education evance. lity policy dated 3/5/13, titled Plan" under step 6. Investigate e resident, the accused, and all ses shall include anyone who: eard the incident; (2) came in the resident the day of the other residents, family employees who worked cused employee (s) and/or lay of the incident. Obtain from the resident, if possible, ach witness." The facility al abuse as, "The use of oral, language that willfully includes progatory terms to residents." o on 3/13/14, at 1:30 p.m. the unable to produce any n any other source regarding stigation, education or training o the specific grievances for , R16 or R63 and stated, "I y weren't reported as verbal istrator thought the grievances could not produce any oincide with the resident ministrator validated the s were verbal abuse and eported to the State Agency. validated the residents should ed pending investigation of the ne abuse prevention plan was or these residents.	21990				
Minnesota D	SUGGESTED MET epartment of Health	HOD OF CORRECTION:					

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Minnesota	Department	of Health

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/13/2014	
		00989 B. WING				
			DRESS, CITY, S	STATE, ZIP CODE E NORTH	-	-
FARIBAU	JLT CARE CENTER	FARIBAU	LT, MN 5502	21		
(X4) ID PREFIX TAG	. (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	
21990	Continued From pa	ge 75	21990			
	potential abuse are immediately reporter residents are proter while an investigation Administrator, direct could assure policies	esure that all allegations of thoroughly investigated and ed to the state agency and that cted from potential retaliation on is pending. The etor of nursing and/or designee es are reviewed, up to date, nd that staff training has been				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
22000	Reporting - Maltrea	6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			
	facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may effect and a statement of to minimize the risk comply with any rul- promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or ree The plan shall conta assessment of: (1) abuse by other indiv vulnerable adults; (2)	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				-

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	•				2	
		00989	B. WING			3/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
22000	Continued From pa	ge 76	22000			
	risk of abuse to tha	o be taken to minimize the t person and other vulnerable poses of this paragraph, the es self-abuse.				
	and personal care a knows that the vuln violent crime or an	except home health agencies attendant services providers, erable adult has committed a act of physical aggression				
	plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Und	ndividual abuse prevention e measures to be taken to at the vulnerable adult might ected to pose to visitors to the outside the facility, if er this section, a facility knows				
· · · · ·	misconduct or physical such information from authority or through another facility, and	It's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by ther health care provider, or g assessments of the				
						•
	by: Based on interview facility failed to impl and procedures to p allegations of poten investigate allegation report allegations o facility's administrat 8 residents (R1, R1	ent is not met as evidenced and document review the lement established policies protect residents who reported tial abuse, thoroughly ons of abuse and immediately f potential abuse to the or and state agencies for 6 of 2, R16, R59, R63, R70) in the				
Minnosoto D	sample who reporte Findings include: epartment of Health	ed allegations of abuse.				

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STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
	· ·	00989	B. WING			C / 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	ULT CARE CENTER	1738 HU	LETT AVENUE	ENORTH		
FANIDA	DEI GARE GENTER	FARIBAU	JLT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
22000	Continued From pa	age 77	22000			
	allegation of potent to thoroughly inves the resident from p	9, R63 and R70 reported an tial abuse and the facility failed tigate the allegation, protect potential abuse while an pending and immediately report e state agency.				
	"Abuse Prevention read, "Interview the witnesses. Witness (1) witnessed or he close contact with 1 incident {including members}; and (3) closely with the acc alleged victim the c written statements the accused, and e policy defines verb	ility policy dated 3/5/13, titled Plan" under step 6. Investigate e resident, the accused, and all ses shall include anyone who: eard the incident; (2) came in the resident the day of the other residents, family employees who worked cused employee (s) and/or day of the incident. Obtain from the resident, if possible, each witness." The facility al abuse as, "The use of oral, language that willfully includes				
a dia tanàna Manjara Manjara	disparaging and de During an interview	on 3/13/14, at 1:30 p.m. with				
	further documentat regarding the prote or training on abus grievance for R1, F and stated, "I don't reported as verbal thought the grievar produce any docum resident complaints the resident complaints the resident complaints the administrator have been protected	she was unable to produce any tion from any other source ection, investigation, education e related to the specific R12, R16, R59, R63 or R70 know why they weren't abuse." The administrator neetation to coincide with the s. The administrator validated aints were verbal abuse and reported to the State Agency. validated the residents should ed pending investigation of the he abuse prevention plan was				

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PRINTED: 03/31/2014 FORM APPROVED

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00989	B. WING		C 03/13/2014	
	PROVIDER OR SUPPLIER	1		STATE, ZIP CODE	03/13/2014	
			ETT AVENU			
FARIBA	JLT CARE CENTER	FARIBAU	LT, MN 550	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 COMPLETE	:
22000	Continued From pa	ige 78	22000			
	not implemented fo	r those residents.				
		HOD OF CORRECTION:				
ta da a	The facility could as	ssure established policies and se prevention plan are				
	implemented, enfor	ced and that allegations of				
	potential abuse are	thoroughly investigated.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
	(21) uays.					
					~	
1. 1.						
in the second se						
Minnesota D	epartment of Health					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00989	B. WING		C 03/1	; 3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ARIBAU	JLT CARE CENTER		ETT AVENU LT, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
				The assigned tag number app far left column entitled "ID Pre The state statute/rule out of co listed in the "Summary Statem Deficiencies" column and repl Comply" portion of the correct This column also includes the which are in violation of the sta after the statement, "This Rule as evidence by." Following the findings are the Suggested Me Correction and Time period fo PLEASE DISREGARD THE H THE FOURTH COLUMN WH STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLI FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAG THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORREC VIOLATIONS OF MINNESOT STATUTES/RULES.	efix Tag." ompliance is lent of aces the "To ion order. findings ate statute e is not met e surveyors ethod of r Correction. EADING OF ICH N OF ES TO NLY. THIS GE. IT TO CTION FOR	
2 380	MN Rule 4658.0200 Residents; Telepho) Subp. 2 Policies Concerning nes	2 380			
	provide at least one which is accessible case of emergency access to a telepho within the building fe home may charge t	es. A nursing home must non-coin-operated telephone to residents at all times in . A resident must have ne at a convenient location or personal use. A nursing he resident for actual long at the resident incurs.				
	This MN Requireme	ent is not met as evidenced				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
FARIBA	JLT CARE CENTER		LETT AVENUE JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 380	Continued From pa	ge 2	2 380			
	review the facility fa	on, interview and document iled to ensure privacy during r 1 of 1 (R46) residents telephone.				
	Findings include:					
	R46 was not provid	ed privacy during phone calls.				
	stated not allowed t	on 3/10/14 at 5:11 p.m. R46 to use the portable telephone taken away. "Make me sit				
	sitting in the hallway nursing station. The were within hearing 10:19 a.m. R46 state provider. R46 state that the use of the of 3/12/14 between 1: observed to use the	on 3/12/14 at 10:05 a.m. y using the telephone in the ree staff and three residents distance. On 3/12/14 at ted the telephone call was to it was to a health care ed did have a cell phone, but cell phone cost money. On 00 p.m. and 3:00 p.m. R3 was e telephone at the nursing When asked, resident stated vere not private.				
	admitted to the men The admission Min 11/5/13 indicated th interview of mental no cognitive impair	nts indicated R46 was mory care unit on 11/5/13. imum Data Set (MDS) dated re resident had a brief status score (BIMS) of 13 or ment, displayed no behaviors, ent with all activities of daily				
	The sign stated, " F	outside the memory care unit. Resident phone is not allowed ntil further notice. Thank you."				

	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•	
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 55021			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 380	Continued From pa	age 3	2 380			
	director of nursing v was available in the stated it was her ur use the telephone f residents to use the incident of being at in area was a privation	on 3/13/14 at 12:10 p.m., the verified no portable telephone e memory care unit. DON inderstanding that R46 would for hours and not allow other e phone. DON verified the the nursing station with staff cy issue, but added the personal cell phone.				
	designee (SSD) on verified the portable the memory care us that the nursing sta use. SSD stated R R46 to have access	with the social service 3/13/14 at 1:00 p.m., SSD e phone was not to be used in nit. SSD stated R46 was told tion phone was available for 46's guardian did not want s to the portable phone to call e phone at the nursing station				
	The facility could as and that staff are tr	THOD OF CORRECTION: ssure that policies are updated ained to assure residents have one and have privacy during				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 540	MN Rule 4658.040 Resident Assessme	0 Subp. 1 & 2 Comprehensive ent	2 540			
	conduct a compreh resident's needs, w capability to perforr	ment. A nursing home must hensive assessment of each which describes the resident's n daily life functions and ents in functional capacity. A				

Minneso	ta Department of He	ealth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	JLT CARE CENTER	1738 HU	LETT AVENUE	NORTH		
		FARIBA	JLT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 540	Continued From pa	age 4	2 540			
	Minnesota Statutes 15, may be used as resident assessme comprehensive res used to develop, re comprehensive pla 4658.0405. Subp. 2. Informa comprehensive res include at least the A. medically de medical history; B. medical stat C. physical and D. sensory and E. nutritional stat F. special treat	ion; ential; n potential; atus; <i>r</i> ; and				
	by: Based on interview facility failed to ass appropriateness of	ent is not met as evidenced and document review the ess 1 of 1 residents (R46) for placement in the care unit at the time of				
	Findings include:					
	dementia unit.	essment for the placement on the locked				
Innesota D TATE FORI	epartment of Health VI		⁶⁸⁹⁹ 4	77C11	If continua	tion sheet 5 of 7

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 55021			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 540	Continued From pa	age 5	2 540			
	11/5/14 directly from initial Preadmission 11/5/13 indicated F management or ins redirection, and had During an interview stated he was only appropriate placem summary dated 11/ stated he did not w Review of the admit (MDS) dated 11/12 (brief interview for no or no cognitive imp displayed no halluc behaviors, no phys	to the locked dementia unit on m an acute care hospital. The n Screening (PAS) dated R46 needed behavior struction, was resistant to d a history of homelessness y on 3/10/14 at 5:06 p.m. R46 50 and felt this was not an nent. The care conference /25/13 indicated R46 had ant to be " locked up " ission Minimum Data Set /13 noted R46 had a BIMS mental status) score of 13/15 airment. The MDS noted R46 cinations, no delusional ical or verbal behaviors, ion of care, and displayed no rs.				
	placement at the Fa appropriate for long unit; an elopement facilities to look for not include interver for continued place unit. Review of the elopement attempts admission. During an interview administrator (ADM	a problem dated 11/6/13 of aribault Care Center was g term care; on the secured risk; had a history of leaving alcohol. The care plan did ntions related to re-assessment ment on the locked dementia documentation revealed no s had occurred since				
	why R46 was in the because he was an	é dementia unit except n elopement risk. ADM stated is was an appropriate				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 55021			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 540	Continued From pa	age 6	2 540			
	direct of nursing (D could climb out eve DON added she we appropriate facility. During an interview social service desig	on 3/13/14 at 12:10 p.m. the ON) stated she believed R46 on with the locked fenced area. ould like to see R46 in an age on 3/13/14 at 1:00 p.m. the gnee stated she was not able ervices documentation related				
	The director of nurs assure that upon a assessment is con- which describes the perform daily life fu impairments in func- nursing or designed	THOD OF CORRECTION: sing and/or designee could dmission, a comprehensive ducted each resident's needs, e resident's capability to unctions and significant ctional capacity. The director of e could monitor to assure that	F			
	determine placeme care unit at the time	opriately assessed to ent in the dementia/memory e of admission. R CORRECTION: Twenty One				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			
	comprehensive pla objectives and time long- and short-tern and mental and psy identified in the corr assessment. The	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 nprehensive resident comprehensive plan of care dividual abuse prevention plan				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	ige 7	2 560			
	required by Minnes subdivision 14, para	ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to dev residents (R40, R7 to develop a plan o non-pharmacologic	ent is not met as evidenced and document review, the elop a plan of care for 2 of 3 0) identified as a fall risk, failed f care that included al interventions for 2 of 5 7) reviewed for unnecessary	ł			
	Findings include:					
	bedroom. The falls	nree, unwitnessed falls, in his occurred on 3/5/14, at 12:53 6:45 p.m. and on 3/9/14 at				
	initiation date of 1/1 1/20/14 revealed th	of care for R70 with an 0/14, and a revision date of at there were no goals or ssing falls or falls with				
	Set (MDS) form dat limited to, hyperter weakness. The MD falls with fracture 2	osis from the minimum Data ted 1/16/14, lists but is not nsion, anxiety and muscle S further indicated a history of 6 months prior to admission. essment addresses falls as a				
	dated 1/16/14, indi	w for Mental Status (BIMS) cated a summary score of 14 5 for cognitive patterns ly intact.				

A. BUILDING. C 00989 B. WING O3/13/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03/13/2 FARIBAULT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 FARIBAULT, MN 55021 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	STATEMENT	a Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
00989 B. WING 03/13/; NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITV, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 PROVIDERS PLAN OF CORRECTION (EACH DECIDENCY WIST REPRECEDED BY FULL (EACH DECIDENCY WIST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION WIST REPRECEDED BY FULL (EACH DECIDENCY WIST REPRECEDED BY FULL (EACH CORRECTION OF LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION OF LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION OF LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION OF LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDER MAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION OF LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDER MAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (ISC ID AD INFORMATION) ID PRETX TAG PROVIDER (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (ISC ID AD INFORMATION) PROVIDE (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (ISC ID AD INFORMATION) ID PRETX TAG (EACH CORRECTION (EACH CORRECTION (ISC ID AD INFORMATION) ID PROVID (ISC ID INFORMATION) ID PROVID INFORM			BENTI IO/TIONTONIBETI.	A. BUILDING: _			
ARBAUTCARE CENTER SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPRICE) TO THE APPROPRIATE DEFICIENCY) O 2 560 Continued From page 8 2 560 2 560 2 560 Image: Continued From page 8 2 560 When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DDN) verified R70 was a fail risk with fracture prior to admission, and R70 had been assessed as a fail risk, which should have been addressed on the plan of care. 2 560 Image: Continued From page 8 2 560 R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of fails, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-22 staff. The resident had a history of fails. R40's initial care plan (with date initiated 1/14/2014) did not address the resident's history of fails and did not address the resident's history of fails and did not address interventions. A fail risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more fails in the last 90 days, resident's confinet or wheelchair and always meeding physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for fails. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care <th></th> <th></th> <th>00989</th> <th>B. WING</th> <th></th> <th></th> <th>C 13/2014</th>			00989	B. WING			C 13/2014
CMAID CARLEAULT CARE CENTER FARIBAULT, MN 55021 (24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROEDED B PY ILL (EACH DEFICIENCY MUST BE PROEDED BY PY ILL (EACH DEFICIENCY MUST BE PROEDED BY PY ILL (EACH DEFICIENCY) ID (EACH DEFICIENCY) PREFIX (EACH DEFICIENCY) 2 560 Continued From page 8 2 560 When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerbral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident's history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. Sh estated R40's care	IAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
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Preferix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY) 2 560 Continued From page 8 2 560 When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. 2 560 R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident's history of falls and did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care				-		CORRECTION	
When interviewed on 3/12/14, at 11:30 a.m. the director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address the resident's history of falls. Bard's initial care plan (with date initiated 1/14/2014) did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
director of nursing (DON) verified R70 was a fall risk with fracture prior to admission, and R70 had been assessed as a fall risk, which should have been addressed on the plan of care. R40 was admitted on 1/11/2014 with diagnoses which included (on face sheet) personal history of falls, intracerebral hemorrhage, obstructive hydrocephalus, schizoaffective disorder, paralysis agitans, and compression of brain. The resident's initial Admission Minimum Data Set dated 1/17/2014 identified the resident as moderate cognitively impaired with extensive to total assist of 1-2 staff. The resident had a history of falls. R40's initial care plan (with date initiated 1/14/2014) did not address the resident's history of falls and did not address interventions. A fall risk assessment dated 1/11/2014 was reviewed. It identified the resident with 3 or more falls in the last 90 days, resident's cognitive status had periods of altered perception or awareness of surroundings, mobility was confined to wheelchair and always needing physical support. R40 had a neuromuscular or functional loss. The assessment indicated the resident was at a higher risk for falls. On 3/13/2014 at 12:50 p.m., the director of nursing was interviewed. She stated R40's care	2 560	Continued From pa	age 8	2 560			
with interventions since the resident had a history of falls. R27's plan of care did not address parameters for use of an anti-anxiety medication and did not address use of non-pharmacological interventions prior to the administration of		director of nursing risk with fracture pr been assessed as been addressed o R40 was admitted which included (on of falls, intracerebra hydrocephalus, sch agitans, and compr The resident's initia Set dated 1/17/20 moderate cognitive total assist of 1-2 s history of falls. R4 initiated 1/14/2014) history of falls and A fall risk assessm reviewed. It identiff falls in the last 90 c had periods of alter surroundings, mob and always needing neuromuscular or f assessment indica higher risk for falls. On 3/13/2014 at 12 nursing was intervi plan (on admission with interventions s of falls. R27's plan of care use of an anti-anxia address use of nor	(DON) verified R70 was a fall rior to admission, and R70 had a fall risk, which should have n the plan of care. on 1/11/2014 with diagnoses face sheet) personal history al hemorrhage, obstructive nizoaffective disorder, paralysis ression of brain. al Admission Minimum Data 14 identified the resident as ely impaired with extensive to staff. The resident had a 40's initial care plan (with date) did not address the resident's did not address the resident's did not address interventions. ent dated 1/11/2014 was fied the resident with 3 or more days, resident's cognitive status red perception or awareness of ility was confined to wheelchair g physical support. R40 had a functional loss. The ted the resident was at a 2:50 p.m., the director of ewed. She stated R40's care a) should have addressed falls since the resident had a history did not address parameters for ety medication and did not n-pharmacological				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAL	JLT CARE CENTER					
			JLT, MN 5502 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 9	2 560			
	not addressed on t	he plan of care.				
	altered mental stat toes, sedative/hypr nondependent can hypertension, esop dependence abuse drug-induced psych hallucinations, para A physician order d	2014 with dx (from care plan) us, traumatic amputation of notic /anxiolytic dependence, nabis abuse, diabetes, hageal reflux, opioid type e, dissociative identity disorder, notic disorder with anoid schizophrenia, lated 2/3/2014 identified R27 5 mg twice daily as needed for				
	severe anxiety. Th psychoactive media Zyprexa, and Trilaf	cations were Buspar, Elavil,				
	reviewed. The resi clonazepam (antiai times in both mont	dated 2/2014 and 3/2014 were ident used the as needed nxiety medication) several hs. The scheduled other cations were given as ordered.				
	of 2/20/2014 was re documentation reg necessary anti-anx address what non	tiated 2/5/2014 and print date eviewed. The care plan lacked arding the use of the as iety medication and did not pharmacological interventions efore giving the as needed anti				
	non-pharmacologic	also lacked documentation of cal interventions attempted stration of as necessary tion.				
	interviewed regardi	2:50 p.m., the DON was ing use of as necessary (prn) tion and stated that non				

STATEMEN	<u>ta Department of Herror Department of Herror Deficiencies</u> OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. DUILDING.			С
		00989	B. WING			13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAL	JLT CARE CENTER		LETT AVENUE ULT, MN 5502 ⁻			
(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 DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 10	2 560			
	attempted prior to t medication. DON s have been develop	terventions should be the as needed anti anxiety stated the care plan should bed to identify the use of the d the non pharmacological				
	needed antianxiety anxiety, monitoring	cal interventions prior to				
	1/9/2014 identified	nary from the hospital dated R40 used as needed riety and every bedtime for				
	falls, schizoactive of compression of bra alcohol use, intrace	2014 with diagnoses hx of disorder, paralysis agitans, ain, parkinson's disease, hx of erebral hemmorrhage, ephalus, insomnia (on MD				
	Lorazepam 0.5 mg needed for anxiety	dated 1/16/2014 identified by mouth every 6 hours as ; and Lorazepam 0.5 mg (4 nouth at bedtime as needed fo	r			
	Lorazepam (antian necessary for sleep	sheets were reviewed: ixiety medication) was used as p and/or anxiety: 1/149 sed 23 times and in 3/14-it				
		, dated 1/13/2014, was ed the resident had difficulty				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	0. 00		A. BUILDING: _			C
		00989	B. WING			13/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 11	2 560			
	history of taking sle to bedtime. An ave hours. R40 had ne Parkinson's diseas environmental fact sleeping difficulties assessment was a	ated to pain; did not have a eep medications routinely prior erage length of nap was 1-2 eurological deficits (stroke, se, seizure disorder). No ors contributing to resident s was identified. The collection of data but did not y or analysis of the data to				
	and print out date of did not address R4 needed antianxiety lacked documenta pharmacological in	th initiated date of 1/14/2014 of 2/20/2014 was reviewed. It 40's sleep issues or use of as 7 medications. The care plan tion regarding what non nterventions should be giving the as needed anti 1.				
	non-pharmacologic	also lacked documentation of cal interventions to be the administration of				
	assistant (TMA)-C of the antianxiety n she did not give the and indicated R40 night for sleep. TMA-C stated the used it throughout was up and about.	1:45 a.m., a trained medical was interviewed regarding use nedication. TMA-C indicated e medication during the day was given the medication at resident got anxious but rarely the day because the resident The TMA did not know if there prior to giving the medication.				
	DON was interview	2:50 p.m. and 1:05 p.m., the ved regarding criteria for use of tion. She stated they should	f			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C	
		00989	B. WING			03/13/2014	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
FARIBA	JLT CARE CENTER		LETT AVENUE JLT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 560	be using non pharm to administering the be following up for checked for sleep r indicated it was not the sleep plan for F assessment data. SUGGESTED MET The director of nurs assure that policies implemented, that s monitoring is done are developed for r that non-pharmaco addressed, attempt	THOD OF CORRECTION: sing and/or designee could and procedures are updated, staff are trained and that to assure resident care plans esidents at risk for falls and logical interventions are	2 560				
2 565	Plan of Care; Use Subp. 3. Use. A co must be used by all care of the resident This MN Requireme by: Based on observati review the facility fa was followed for 1 o with urinary incontir	5 Subp. 3 Comprehensive omprehensive plan of care l personnel involved in the ent is not met as evidenced on, interview and document tiled to ensure the care plan of 3 residents (R25) observed hence and 1 of 3 residents assistance with hearing aides.	2 565				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
FARIBAL	JLT CARE CENTER						
			JLT, MN 5502				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 13	2 565				
	Findings include:						
	accordance with th	e incontinence care in e plan of care. During three tinence care exceeded the 2 he care plan.					
	The care plan printed 2/13/14 was reviewed. The care plan had a focus of, "staff assist with toileting" and directed staff to offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule.						
	observed to be lyin two soaker pads ur observed to be pro 3.5 hours. On 3/12 10:25 a.m. to 1:30 be provided contine Nursing assistant (repositioned and as total of 3.5 hours. at 12:00 p.m. to 1:3 received incontiner hours) NA-J stated to R25 at 10:00 a.m 3/13/14 R25 was o a.m. and no incont NA-C stated she ha	00 pm to 7:30 p.m.R25 was g on his back in bed. R25 had nder him. R25 was not vided incontinence cares for 2/14 R25 was observed from p.m. R25 was not observed to ence cares for 3 hours. NA)-J stated she had last ssisted R25 at 10:00 a.m. or a R25 was observed on 3/12/13 80 p.m. At 1:30 p.m. R25 nce care (by observation 1.5 d she had last provided cares n. (a total of 3.5 hours) On bserved from 7:09 a.m. to 8:58 tinence cares were provided. ad worked all night and had epositioned R25 at 5:30 a.m. ours).	3				
	3/13/14 at 11:45 a. expect the care pla resident refused ca	sing (DON) was interviewed or m. DON stated she would in to be followed. If the ares, she would expect staff to res. DON stated she had not					

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	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: B. WING		C	
		00989				03/13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	age 14	2 565			
	been contacted by receive incontinenc	staff related to R25 refusing to ce cares.				
		assistance with hearing aides rding to the plan of care.				
	am at risk for socia of hearing. Make co aides prior to the st Furthermore, the p	lan of care revised 7/10/13, sive hearing loss. Potential for				
	7:00 p.m. R4 was of able to hear despite present in the left e the missing hearing not know what the or replacing the hea NA-B came into the did not know what I or why the one in th When asked how of shrugged shoulders work, I'm used to h attempted to chang could not hear the	and interview on 3/10/14, at complaining about not being e having a hearing aide ear. R4 said she had reported g aide to her right ear, but did facility was doing about finding aring aide. Nursing assistant e room and when questioned happened to the hearing aide ne left ear was not working. to you communicate NA-B s and stated, "We make it er." The nursing assistant ge the battery for R4 but R4 conversation which surveyor imputer for R4 to read and				
	R4 was on her way not have her hearin designee (SSD) wa hearing aides and o	ion on 3/13/14, at 11:50 a.m. to the beauty shop and did ng aides in. The social service as questioned about the did not have a missing item or was not aware the right hearing				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00989	B. WING			03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
FARIBAU	JLT CARE CENTER		LETT AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 565	aide was missing. <i>A</i> she found the heari cart and put them ir now, they are worki On 3/13/14 at 3:00 stated, "This is not ear) these are my c work." R4 was not a Interview with RN-A hearing aide was m hearing aide last we SUGGESTED MET The director of nurs assure that care pla implemented, staff assure the care pla	About 1:00 p.m. the SSD said ng aides in the medication n R4's ears and she can hear ng just fine. p.m. R4 was interviewed and the new one, (pointing to right old hearing aides that don't able to hear surveyor. A verified she did not know the tissing and thought R4 had the eek. CHOD OF CORRECTION: sing and/or designee could	2 565				
2 830	MN Rule 4658.0520 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	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					

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TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00989	B. WING		C 03/13/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1738 HU	LETT AVENUE	NORTH		
ARIBAU	JLT CARE CENTER	FARIBAU	JLT, MN 5502 [.]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ae 16	2 830	DEFICIENC	, i (
2 000	Commed From pa	90 10				
	This MN Requireme	ent is not met as evidenced				
	Based on observati review, the facility facare and services v assessment, develo	on, interview, and document ailed to ensure the necessary vere provided, based on opment of a care plan, and				
	residents (R39, R46	o pain management for 3 of 3 6, R29) who were reviewed for ent (R25) who was reviewed es.				
	Findings include:					
	and was not compr to develop effective interventions to min identify which as ne	ing migraine headache pain ehensively assessed for pain non pharmacological imize pain, develop criteria to eeded pain medication was to effectiveness of as necessary en administered.				
	nurse for pain medi the bedroom doorw nurse shut the light would get some or 6:49 p.m., the resid	30 p.m., R39 was looking for a cation. R39 was standing in ray with the call light on. The off and told the resident she check on the medication. At ent was sitting in the bedroom				
	migraine and would time but maybe tom medical assistant (⁻	resident indicated had a l rather not interview at that norrow. At 7:00 p.m. a trained TMA)-C went down the hall cart but didn't stop to give				
	migraine. At 7:10 p. and stated she was	pain medication for the m., TMA-C was interviewed s just told about the Tylenol s after the resident requested				

	F CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AME OF PR						
AME OF PR		00989			C 03/13/2014	
			DRESS, CITY, ST	TATE, ZIP CODE		
ARIBAUL	T CARE CENTER		LETT AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 17	2 830			
a s h s a r h T 7 2 0 c r t i	ask R39 what the p he would check ar have it. At 7:15 p.m haid the last time th at 1:45 p.m. and co eceived it every 6 h have oxygen on con The TMA indicated 2:45 p.m. then coul 2 tabs. The TMA si but why R39 was go equested pain med	reak, and she was going to bain medication was for and ad see if the resident could n., TMA-C came back and he resident had the Tylenol was uldn't have it because hours. R39 was suppose to ntinuously but wouldn't do it. the resident had to wait til d have the Tylenol ES 500 mg tated they are trying to figure etting the migraines and dication every night at this ological interventions were not d.				
s b c c f t t t r r	sitting in the dining bath today and was a.m., was observed on and then sitting i At 11:50 a.m., was he lights off. At 1:2 equesting a pain m	00 a.m., R39 was observed room and stated didn't take short of breath. At 10:00 I up and about without oxygen in the lobby without oxygen on. observed resting in bed with 20 p.m. was in bed resting and nedication for headache. Non terventions were not offered or				
e ti h	edge of bed. At 1:2 he window, and st	45 a.m., R39 up and sitting on 20 p.m. in lobby, looking out ated feeling better today, and eadache. At 3:20 p.m., R39 aned room resting.				
a r v	and at 9:00 a.m. wa esting. At 11:46 a.	00 a.m., R39 was out of room as in room laying on the bed m., the resident was up being outside and would not ten to.				
	R39 was readmitted artment of Health	d to the facility on 6/12/2013				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·			
		00989	B. WING			C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 55021				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 18	2 830				
	diagnoses on the c obstructive pulmon carrier, cardiac dise nondependent coca persisting dementia A quarterly Minimur 9/20/2013 identified cognitive impairme regime, received as and occasional pair The intensity of the significant change the resident's cogn scheduled pain reg medication offered	th was listed in the medical omputer and included: chronic ary disease, hepatitis C ease, esophageal reflux, aine abuse, drug-induced a, and hypertension. m Data Set (MDS) dated d the resident with moderate nt, on a pain medication s necessary pain medications, n affected activities and sleep. pain was rated as 8. A MDS dated 2/7/2014, identified itive status as moderate, no ime; as necessary pain s pain was present, almost affect sleep or activities. The n was rated at 7.					
	The resident was id type headache, and which was increas recommended. (ad scheduled for 4/2/2 had chronic tension every 6 hours was medication. No im medication, minima some improvement noted and with ong morphine medication	ted 2/26/2014 were reviewed. dentified with chronic tension d was on Depakote medication ed. A Neurology consult was ccording to staff appointment is 2014). 1/29/2014, the resident in type headache and Ibuprofen started and Depakote provement with tramadol al improvement with Tylenol, t with morphine but daily use oing pain. The tramadol and ons were discontinued.					
	and 12/14/2013, b come up with a sur plan identifying crite	t was completed on 7/12 2013 ut the data was not analyzed to nmary of the pain issues, a eria to be used to determine tion to be given and a plan for					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 19	2 830				
	The resident was o medications.	n 3, as necessary, pain					
	following: For 12/2 mg every bedtime; as necessary for h 12/15-12/31) and T hours as necessary used tramadol ever times, Ibuprofen 40 was used 3 x for he mg ES every 6 hou times, and morphir needed for modera many times. For 2/2 mg daily as necess times; used the ibu and the acetaminop For 3/2014, the ibu were given several	eets were reviewed for the 013, R39 used Tylenol 1000 tramadol 50 mg every 6 hours eadache used (8x from ylenol ES 500 mg every 6 v for pain; for 1/2014, R39 y 6 hours as necessary 26 00 mg every 6 hours as needed eadache, acetaminophen 1000 rs as needed used many ne sulfate every hour as te to severe pain was used 2014, R39 was on Imatrex 100 sary. The resident used it 15 profen medication many times ohen 1000 mg ES many times. uprofen and acetaminophen times as necessary.					
	criteria to identify w which of the many a for the resident's pa Non pharmacologic	hen to use the medication and as needed medications to use ain issues. cal interventions or as needed pain medication					
	indicated the follow intermittent headac interferes with my a doesn ' t interfere w ADL's. My pain ma scale. On 10-13 m testing (CD scan of sleep study) and or	h print date of 2/13/2014 ing: I have frequent hes (chronic for me). Pain ability to sleep at times, but with my ability to do my own by be as bad as 7/10 on a pain y provider ordered extensive sinus, neurology follow up, nee ordered I refused all of anticipate my need for pain					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	or connection	IDENTITION TON NOMBER.	A. BUILDING: _	·····			
		00989	B. WING			C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻				
(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 ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 20	2 830				
	effectiveness of pa call for assistance. controlled by Topar lbuprofen. Use of history of poly-subs effects of pain mec necessary Tylenol,	immediately. Evaluate the in interventions, I am able to I prefer to have pain max, melatonin, Tylenol and narcotics is discouraged due to stance abuse. monitor for side I, prior to administering as utilize non-pharmacological as ice for my head, relaxation ent effectiveness.					
	assistant (TMA)-C of as needed (prn) documentation. Th document prn pain (medication admini	2:30 p.m., a trained medical was interviewed regarding use pain medications and MA-C stated they are to medication on back of MAR istration record) and low up, but not always					
	director of nursing regarding pain asse needed pain medic assessments were of the data was not plan. The use of p medication should and follow up for ef MAR. The staff we form in front of the included all the cor MAR's did not have and the DON state There should be cr medication to use a find the criteria.	2:50 p.m. and 1:05 p.m., the (DON) was interviewed essments and use of as cations. She indicated the pain data collection but an analysis t completed to determine a rn (as necessary) pain be documented on the MAR ffectiveness should be on the re to use a pain management MAR for each resident which nponents. When checked, the e the pain management forms d the staff were not doing it. iteria related to which pain and when and she could not ed Non pharmacological	5				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED
		00989	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
FARIBAU	ULT CARE CENTER		_ETT AVENUE ILT, MN 5502 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 21	2 830			
	medication adminis	tration.				
	lacked a plan of car interventions for pa related to pain man R46 was admitted t care conference su indicated R46 had o alcohol induced per	o the facility 11/5/13. The mmary dated 11/25/13 diagnoses that included sisting dementia, bipolar				
	400 mg 1 tab by mo needed for pain, lid	gned 2/5/14 include ibuprofen buth three times daily as ocaine 5% patch apply 1 patch n for 12-hours off for 12-hours,				
	stated he had pain he had numb feet. was asked if he had ankle and foot num wanted the lidocain stated he had back 10. R46 stated he patch placed on his stay put. R46 was survey 1/10/14 thro	on 3/10/14 at 5:00 p.m. R46 but would not rate it. Stated On 3/13/14 at 7:45 a.m. R46 d pain. R46 stated he had bness and that was where he e patch placed. R46 also pain that he rated at a 7 out of did not want the lidocaine back because it would not observed on all days of the ugh 3/13/14 to transfer come to a stand, and walk				
	reviewed. As needed January for compla documentation of n document the inten non-pharmacologic	ninistration record was ed ibuprofen was given twice in ints of back pain. The ursing observations did not sity of the pain or if any al interventions had been medication had been effective.				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FARIBA	ULT CARE CENTER		ETT AVENUE			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	The as needed ibur during February. N recorded four times given for mouth pai pain or if any non-p had been attempted observations indica given once during th Nursing observation medication was adr The treatment adm reviewed. Pain was each day. The doc not experience pain The facility's pain as 2/5/14. The assess experienced pain fr on a scale of 00-10 addressed). The ca for pain dated 11/25 experienced pain at the pain was almos findings indicated F ankle injury and wa physician. The CA frequency or intens non-verbal indicator signs and symptom potential causal fac effectiveness of any The plan of care pri of pain medication administer medicati	brofen was given 6 times ursing observations were indicating the medication was n but lacked intensity of the harmacological interventions d. Three of the four ted relief. Ibuprofen was he first 2 weeks of March. Ins did not record the ministered. inistration record was is documented once per shift umentation indicated R46 did n ssessment was completed on sment indicated the resident equently that was rated at 4 (mild to severe intensity not are area assessment (CAA) 5/13 indicated the resident t constant. The analysis of R46 had pain related to an is being managed by the A did not evaluate the ity of pain, if there were any rs of pain, or any associated is related to the pain, any tor of pain, or the y pain management program. inted 2/18/14 indicated a focus with an intervention to ion as ordered. The plan of where the pain was located iacological interventions to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _		с	
		00989	B. WING		03/13/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	director of nursing pain medications n location, intensity a she had just update	v on 3/13/14 at 12:10 p.m. the (DON) stated with as needed purses were to document pain and effectiveness. DON stated ed the care plans, but that all nsible for keeping the care	ł			
	R29 lacked a comprehensive pain assessment and the development of a plan to manage the residents pain.					
	R29 was slow to co bed. R29's face ap her back hurt. R29 burned because of observed during no p.m. R29 was eati	on 03/11/2014 at 10:27 AM. ome to a sitting position in the opeared pained. R29 stated also stated that her mouth decayed teeth. R29 was oon lunch on 3/12/14 at 12:23 ng a regular diet independently ut what she called meat n burned.	/			
	diagnoses listed or record as osteopor and pain. R29 had Acetaminophen 32	to the facility in 2009. R29 had in the medication administration rosis, depression, dementia, a physician's order for 25 mg tablet. 2 tabs by mouth 4 i. No as needed medication if found.				
	the resident compli- intermittently and h R29 had a physicia	umentation of 1/15/14 noted ained of back pain nad a diagnoses of lumbago. an's order dated 10/12/11 for olets 2 tabs four times daily.				
	The quarterly Minir	num Data Set (MDS) dated				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00989	B. WING			C 03/13/2014			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE					
FARIBAULT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE			
2 830	Continued From pa	ige 24	2 830						
	interview for mental cognitive impairment had pain and that m interventions were intensity of the pain The care area asset was reviewed. The "presumably the lac BIMS is a result of CAA noted : numer and that resident in constantly. The CA Tylenol currently. The facility pain asset indicated denied pain pain occasionally. of 00-10 at a 3 or m indicated R29 woul when in pain and re The assessment di was located, what we the pain and if an a	used. The frequency and							
	The care plan print reports moderate p arthritis of hips and scheduled use of T as per MD orders a Give PRN meds for medications ordere pains and discomfor complaints and nor care plan lacked no interventions to ass	ed 2/13/14 had a focus: ain frequently related to back. Interventions: ylenol. Administer medication and note the effectiveness. r breakthrough [no PRN ed] acknowledge presence of ort. Document/report n-verbal signs of pain; The							

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:		-		
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE			
FARIBA	JLT CARE CENTER		LETT AVENUE JLT, MN 55021				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	ge 25	2 830				
	PRN symptoms of The care plan lacke	nitor/document/report to MD oral pain needing attention. ed non-pharmacological ist R29 to manage her oral					
	3/13/14 at 12:36 p.r aware of dental issu resident 's mouth b not sure the facility cognitively impaired been an issue for R complained of back the care plan should	sing (DON) was interviewed on m. DON stated she was ues, but unaware of the burning. DON stated she was had a pain assessment for the d, but did know that pain had k29. DON stated R29 k pain last week. DON stated d be revised as necessary and low the plan of care.					
		ed appropriate positioning hair or when in bed during					
	7:30 p.m. lying in be elevated. At 6:05 p and the head of the R25 was observed the foot of the bed a he sat in an upright Licensed practical r resident higher in th up without assist of at 8:25 a.m. R25 w head of bed elevate been provided to th (RN)-A came to the the resident. RN-A	on 3/10/14 from 4:00 p.m. to ed with the head of the bed .m. R25 received his meal bed was elevated further. to have feet extended beyond and was not positioned so that position to eat safely. hurse (LPN)-I repositioned the bed by pulling the resident 2 staff members. On 3/13/14 vas observed lying in bed with ed and a breakfast tray had e resident. Registered nurse resident's room to observe stated the resident was not to eat the meal safely and left					

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		BENTH IONHON NOMBER.	A. BUILDING:				
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
FARIBAU	ULT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 26	2 830				
	dated 11/7/13 did n positioning and eat printed 2/13/14 ider assist with ADLs. I 2 to boost up in bec with eating, but did	sessment for nutritional status ot identify R25's safety with ing in bed. The care plan ntified a focus/problem of need nterventions included assist of d dated 2/17/14, independent not direct the resident was to safe positioning to eat in bed.					
	in the wheelchair. the back of the whe the floor, R25's was that his thighs were The wheelchair cus edge of the chair.	a.m. R25 was observed sitting R25's back was not against eelchair, R25's feet were on s sitting forward in the chair so beyond the edge of the chair. shion was beyond the front When asked R25 stated he e sitting in the chair.					
	stated she had just wheelchair and new	a.m. occupation therapist provided R25 with a larger v cushion, but that she had no vheelchair positioning.	t				
	focus/problem of ne Interventions incluc mobility on the unit, almost every time. and ask again kind needs to be reported	ed 2/13/14 identified a eed staff assist with mobility. ded use a wheelchair for , will refuse to reposition Explain why it has to be done ly. If I am non-compliant it ed to nurse and if nurse canno osition, report to director of	t				
	director of nursing expected to follow t	on 3/13/14 at 11:45 a.m. the (DON) indicated staff were the care plan. If the resident , staff should then re-approach	1				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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		00989	B. WING			03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 27	2 830				
	the resident. DON had refused to be r	stated she was unaware R29 repositioned.					
	The director of nurs assure that policies necessary, staff are assure all residens treatment, persona supervision based preferences as ide	THOD OF CORRECTION: sing and/or designee could s are reviewd, revised as e trained and monitored to t receive nursing care and and custodial care, and on individual needs and ntified in the comprehensive ent and plan of care.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One					
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910				
	have a continuous management to red unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trad	nce. A nursing home must program of bowel and bladder duce incontinence and the of catheters. Based on the sident assessment, a nursing that: who enters a nursing home ing catheter is not catheterized t's clinical condition indicates in was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.					
	This MN Requirem	ent is not met as evidenced					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONTECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	lge 28	2 910			
	review the facility fa comprehensive urir	nary incontinence assessment rvices for 2 of 3 (R25, R46)				
	Findings include:					
	assessment that in	orehensive incontinence cluded voiding patterns and services in accordance with				
	1/24/14 was review diagnoses of deme disorder. The MDS total dependence o living-including toile	imum Data Set (MDS) dated red. The MDS identified ntia, depression, psychotic of 1/24/14 indicated R25 had n two staff for activities of daily eting care; did not have a was always incontinent.	/			
	Assessment check R25 had incontinen and impaired mobil functional incontine documented. The Intervention Guideli completed check lis functional incontine assessment for pai bladder elimination elimination pattern, voiding. The Tool c data to determine w were noted and wh	ine Tool dated 2/13/14 had a st that identified R25 as having ence and recommended an n, scheduling of a 3 day tracking to establish and implementing prompted did not have an analysis of vhy the recommendations at the outcome of the bladder				
	Continence Risk As	was. The Urinary and Bowel ssessment and Urinary ntion Guideline Tool did not				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00989	B. WING			C 03/13/2014	
				03/	13/2014	
JLT CARE CENTER						
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Continued From pa	ge 29	2 910				
identify other contri factors, psychologic medications and m care plan was not c	buting factors such as physical cal factors, behavioral factors, edical diagnoses factors. A leveloped based on					
The care area assessment (CAA) dated 11/7/13 indicated R25 required extensive assistance for toileting and was always incontinent. The analysis of findings noted R25 was highly resistive to toileting. The CAA identified urinary urgency, diabetes, congestive heart failure and depression as contributing factors, but did not identify the type of incontinence or the voiding pattern/frequency. The CAA did not provide a plan of care based on the evaluation.						
care plan had a foc toileting" and direc hours and per requ	us of "staff assist with ted staff offer toileting every 2 est. On 2/13/14 a change was					
observed to be lying soaker pads under to be provided inco On 3/11/14at 11:10 strong urine odor w 1:30 p.m. R25 was wheelchair. A stron the crotch of R25's wet. On 3/12/14, F a.m. to 1:30 p.m. R provided incontiner assistant (NA)-J sta and assisted R25 a	g on back in bed. R25 had two him. R25 was not observed ntinence cares for 3.5 hours. a.m., while visiting R25, a vas detected. On 3/11/14 at observed sitting in the g urine odor was detected and pants was observed to be R25 was not observed to be R25 was not observed to be nee cares for 3 hours. Nursing ated she had last repositioned tt 10:00 a.m. or a total of 3.5					
	PROVIDER OR SUPPLIER JLT CARE CENTER SUMMARY STA (EACH DEFICIENCC REGULATORY OR L Continued From pa identify other contri factors, psychologic medications and m care plan was not c assessments and e The care area asse indicated R25 requ toileting and was al analysis of findings resistive to toileting urgency, diabetes, depression as cont identify the type of if pattern/frequency. plan of care based The care plan printe care plan had a foc toileting" and direc hours and per requ made to the care pl change schedule. On 3/10/14 from 4: observed to be lying soaker pads under to be provided inco On 3/11/14at 11:10 strong urine odor w 1:30 p.m. R25 was wheelchair. A stron the crotch of R25's wet. On 3/12/14, F a.m. to 1:30 p.m. R provided incontiner assistant (NA)-J sta and assisted R25 a	OF CORRECTION IDENTIFICATION NUMBER: 00989 00989 PROVIDER OR SUPPLIER STREET AD DILT CARE CENTER 1738 HULL FARIBAU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. A care plan was not developed based on assessments and evaluation. The care area assessment (CAA) dated 11/7/13 indicated R25 required extensive assistance for toileting and was always incontinent. The analysis of findings noted R25 was highly resistive to toileting. The CAA identified urinary urgency, diabetes, congestive heart failure and depression as contributing factors, but did not identify the type of incontinence or the voiding pattern/frequency. The CAA did not provide a plan of care based on the evaluation. The care plan printed 2/13/14 was reviewed. The care plan had a focus of "staff assist with toileting" and directed staff offer toileting every 2 hours and per request. On 2/13/14 a change was made to the care plan that directed a check and change schedule. On 3/10/14 from 4:00 p.m., to 7:30 p.m., R25 was observed to be lying on back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/11/14 at 11:10 a.m., while visiting R25, a strong urine odor was detected. On 3/11/14 at 1:30 p.m. R25 was observed sitting in the	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00989 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NLT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH COPRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF (EACH COPRECTIVE AC COOSS REPERENCED OF FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF (EACH COPRECTIVE AC CROSS REPERENCED OF DEFICIENC Continued From page 29 2 910 2 910 Identify other contributing factors such as physical factors, psychological factors, behavioral factors, medications and medical diagnoses factors. A care plan was not developed based on assessments and evaluation. 2 910 The care area assessment (CAA) dated 11/7/13 indicated R25 required extensive assistance for toileting and was always incontinent. The analysis of findings noted R25 was highly resistive to toileting. The CAA identified urinary urgency, diabetes, congestive heart failure and depression as contributing factors, but did not identify the type of incontinence or the voiding pattern/frequency. The CAA did not provide a plan of care based on the evaluation. The care plan printed 2/13/14 was reviewed. The care plan had a focus of "staff assist with toileting" and directed staff offer toileting every 2 hours and per request. On 2/13/14 a change was observed to be lying on back in bed. R25 had two soaker pads under him. R25 was not observed to be provided incontinence cares for 3.5 hours. On 3/10/14 from 4:00 p.m., to 7:30 p.m., R25 was otobserved to be p	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00989 B. WING 03/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T738 HULETT AVENUE NORTH IT CARE CENTER T738 HULETT AVENUE NORTH PROVIDER'S PLAN OF CORRECTION SECULD BE IEACH DEPICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION SECULD BE IEACH DEPICIENCY MUST BE PRECEDED BY FULL ID PRETW CROSSHEET ADDRESS, CITY, STATE, ZIP CODE Continued From page 29 2 910 COM EACH OPERCIPICATION SECULD BE CROSSHEET ADDRESS PLAN OF CORRECTION OF CONSHEULD BE Continued From page 29 2 910 2 910 EACH OPERCIPICATION SECULD BE CROSSHEET ADDRESS Continued From page 29 2 910 2 910 EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS Continued From page 29 2 910 EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS Continued From page 29 2 910 EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS Continued From page 29 EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS EACH OPERCIPICATION ADDRESS Continued From pa	

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED		
		00989	B. WING	B. WING		C 03/13/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE				
FARIBAULT CARE CENTER 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 910	incontinence care (NA-J stated she ha 10:00 a.m. (a total of was observed from incontinence cares she had worked all and repositioned R 3.5 hours). During an interview stated two soaker p when in bed becaus prevents soak throu The director of nurs 3/13/14 at 11:45 a.r incontinence asses completed. The as hour bowel and bla- exists. The notation be included on the would expect the car resident refused car re-approach for car been contacted by receive incontinence R46 lacked a comp plan of care for incon R46 was observed	by observation 1.5 hours) d last provided cares to R25 at of 3.5 hours) On 3/13/14 R25 7:09 a.m. to 8:58 a.m. and no were provided. NA-C stated night and had last changed 25 at 5:30 a.m. (greater than of on 3/12/13 at 1:30 p.m. NA-J bads were under the resident se he "wets a lot and this ugh." sing (DON) was interviewed on m. DON stated the urinary sments were just being sessment was to include a 72 dder diary to see if a pattern ns on the assessments should care plan. DON stated she are plan to be follow. If the res, she would expect staff to es. DON stated to R25 refusing to e cares. orehensive assessment and portinence. on 3/10/14 at 4:10 p.m. A		DEFICIENC	·Υ)			
	nurse (LPN)-I state was unsure if the or resident. LPN-I stat cleaned up. No stat incontinence or odd at 10:05 a.m. and a	vas noted. Licensed practical d he also noticed the odor but dor was from R46 or another ed R46 did not like to get iff interventions related to the or was observed. On 3/12/14 t 10:25 a.m. R46 was the nursing station with 3 staff						

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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		00989	B. WING		03/	03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 910	Continued From pa	age 31	2 910				
	noted. No staff inte incontinence and o 3/13/14 at 7:10 a.m detected. R46 was same clothing as th During an interview nursing assistant (N odor, when near F4 get a shower twice observed to interve R46 was admitted	v on 3/13/14 at 7:50 a.m. NA)-C verified a strong urine 46. NA-C stated R46 was to a week. NA-C was not					
	alcohol-induced pe disorder, and traum	rsisting dementia, bipolar natic brain injury.					
	11/12/13 and the que both identified R46 interview for menta	imum Data Set (MDS) dated uarterly MDS dated 1-12-14 as having a BIMS score (brief I status) of 13 or no cognitive always be continent.					
	December docume every other day due documented the re- was not given the c Conference Summ	ord for November and ented R46 was to get a shower e to incontinence but sident frequently refused or opportunity. The Care ary dated 11/25/13 noted ate [sp] in pants and refuse to					
	Bowel Continence checklist identified without documenta that a physician exa identified nocturia,	ty completed Urinary and Risk Assessment. The impaired bladder emptying tion of a post void residual or am had been completed, and determined the resident acteristics of overflow					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00989	B. WING	B. WING		C 03/13/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻				
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	bladder/urge incom not identify other co physical factors, per factors, medication factors. The assess of care based on the found or provided f Review of the care reveal a plan/interve manage incontinent the resident as inde living. The care plater refused cares, the notified. The director of nurst 3/13/14 at 11:45 a. incontinence assess completed. The ass hour bowel and blater exists. DON states refusal of cares. SUGGESTED MET The director of nurst assure that policiess that staff are traine each resident is ass that a continuous p management is imp	haracteristics of over active tinence. The assessment did ontributing factors such as sychological factors, behavioral is and medical diagnoses ssments did not provide a plan he evaluation. No CAA was or urinary incontinence. plan dated 2/18/14 did not rentions to assist R46 to ice. The care plan identified ependent with activities of daily an also directed if the resident director of nursing was to be sing (DON) was interviewed or m. DON stated the urinary ssments were just being ssessment was to include a 72 idder diary to see if a pattern d she had not been notified of THOD OF CORRECTION: sing and or designee could s and procedures are current, d and monitored to assure sessed for toileting needs and program of bladder plemented and evaluated to	,				
	The director of nurs assure that policies that staff are traine each resident is as that a continuous p management is im reduce incontinence incontinent of blade	sing and or designee could s and procedures are current, d and monitored to assure sessed for toileting needs and program of bladder plemented and evaluated to be and that a resident who is der receives appropriate ices to restore as much					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00989	B. WING		03/	13/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ LETT AVENUE			
FARIBAL	JLT CARE CENTER		JLT, MN 5502 [°]			
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ige 33	2 910			
	(21) days.					
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure provision of resident (R25) observed who e with grooming.				
	Findings include:					
	R25 lacked person hair.	al grooming to remove facial				
	dated 1/24/14 ident dementia, depressi	terly Minimum Data Set (MDS) iffied diagnoses of diabetes, on, psychotic disorder. The tal dependence of two staff for ing.				
	3/10/14 through 3/1 R25 was noted to b 10:25 a.m. R25 was	throughout the survey of 3/14. On 3/11/14 at 9:30 a.m. be unshaven. On 3/12/14 at s noted to be unshaven. On a., R25 was again observed to				
	R25 was interviewe	ed on 3/11/14 at 8:38 a.m. R25	5			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00989	- B. WING	B. WING		C 03/13/2014	
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	JLT CARE CENTER	1738 HU	LETT AVENUE JLT, MN 5502	NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	stated that staff wo day and had not sh The care plan print behavior problems. resistive to cares st determine the optio leave and re-appro- resistive. The care resistive to care wit resist ADLs, reass minutes later and tr identified a focus no interventions for gr assist of 1 staff and comb own hair and interventions did no related to shaving. During an interview nursing assistant (N aid (TMA)-E stated Friday and that R25 shaven. The director of nurs 3/13/14 at 11:45 a.r	uld only shave him every other aved him this day. ed 2/13/14 identified a focus of Interventions directed if taff should have a nurse on that is least detrimental; ach later if continued to be plan identified a focus of h interventions that directed if ure, leave and return 5-10 ry again. The care plan eeds assist with ADL's and boming that directed staff need d encourage participation to brush teeth. The of provide staff with directions a on 3/12/14 at 1:30 p.m. NA)-J and trained medication R25 was last shaved on 5 did not always agree to be sing (DON) was interviewed or m. DON stated she would be included in the care plan	f				
	resident refused ca re-approach for car	In to be followed. If the res, she would expect staff to res. DON stated she had not staff related to R25 refusing to					
	The director of nurs ensure that residen activities of daily liv	HOD OF CORRECTION: sing and or designee could ts who are unable to carry out ing receive the necessary n good nutrition, grooming,					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		С	
		00989			03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENUE ULT, MN 55021			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 920	Continued From pa	ige 35	2 920			
	and personal and c	oral hygiene.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One	•			
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observat review the facility fa thickened liquids as	ent is not met as evidenced ion, interview and document ailed to ensure the provision of s ordered by the physician for 9) reviewed with thickened				
	Findings include:					
	R29 was not provid meals.	led thickened liquids during				
	diagnoses that inclu	to the facility in 2011 and had uded diabetes, Alzheimer's, ing to the physician orders				
		on 3/12/14 at 12:20 p.m. endently. R29 had been				

STATEMEN	Dia Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAL	ULT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	served a regular dia tray were a glass o cup of tea. At 12:3 (TMA)-E placed a s stated the fluids we stated she had not eating. R29 was ob meal on 3/13/14 at regular diet and this juice, milk, water.) thin. Nursing assis never had thickene started working in t verified on the med R29's liquids were proceeded to use the The physician order 12/31/13, 2/5/14, 3 ADA/mechanical se for thin milk on cere therapist recomme tray card on the med was to receive nect assessment (CAA) type of diet R29 wa The quarterly Minin 1/13/14 indicated F assist of one staff, was on a therapeut speech therapy. T	et with regular liquids. On the f water, a glass of juice and a 30 p.m. trained medication aide spoon into each glass and ere of thin consistency. TMA-E observed R29 to cough while oserved during the morning 8:15 a.m. R29 was served a n liquids (orange juice, prune TMA-F stated the liquids were stant (NA)-C stated R29 had ed liquids since NA-C had the facility a year ago. TMA-F dication administration record to be nectar thick and hickener. ers dated 10/26/13, 11/27/13, /12/14 all ordered Liberal off with nectar thick liquids. Ok eal. On 2/12/13 the speech nded nectar thick liquids. The eat tray identified the resident tar thick liquids. The care area dated 8/5/13 did not identify	ı	DEFICIENC	Υ)	
	initiated 6/7/11 and stated R29 had a s difficulty with regula	plan identified a problem revised on 10/11/13 that wallowing problem related to ar food. Coughing or choking vallowing medication.				

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
FARIBAU	ULT CARE CENTER		LETT AVENUE ILT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 965	Interventions dated followed as prescril mechanical soft tex During an interview administrator stated were to be thickened an interview on 3/13 stated she was una thickened liquid unt note from licensed the diet order was of LPN-J was interview stated that since las	Age 37 4/20/13 indicated diet to be bed: liberal diabetic, attures with thin liquids. To n 3/13/14 at 8:33 a.m. the d she was aware the liquids ed and had not been. During 3/14 at 1:00 p.m. cook-C aware of the need for the sil today when she received a practical nurse (LPN)-J that changed to thin liquids. w 3/14/14 at 1:10 p.m. and st August when LPN-J started ty, R29 had not received	2 965				
	The director of nurs staff and monitor st thickened liquids as provided to residen	THOD OF CORRECTION: sing could review policies, train caff to ensure the provision of s ordered by the physician are ts. R CORRECTION: Twenty One					
21390	MN Rule 4658.0800 Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for	D Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and s of infectious diseases;	21390				

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AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF PRO	VIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
FARIBAULT	CARE CENTER		LETT AVENUE JLT, MN 55021			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
21390 Co	ontinued From pa	ge 38	21390			
pr im de pr th er pr de	duce risk of trans D. in-service ed evention and conf E. a resident he munization progra efined in part 465 ocedures of resid e prevention and F. the developm nployee health po actices, including efined in part 4658 G. a system for H. a system for oducts which affe sinfectants, antise continence produce I. methods for r	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of licies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				
by Ba re to ch tul iso re fa ec Fi R4 dr	r: ased on observation view, the facility fat prevent the spreat be dressing and the olation precaution sidents (R48) with iled to assure 1 of quipment was san ndings include: 45 had a gastric for essing change, in	ent is not met as evidenced on, interview, and document ailed to implement procedures ad of infection during dressing sidents (R45) with a gastric ube feeding, failed to ensure s were adhered to for 1 of 1 n isolation precautions and f 1 residents (R10)Nebulizer itized between use.				

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00989	B. WING	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
FARIBA	ULT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21390	Continued From pa	age 39	21390				
	diagnoses (listed fr included: encepha traumatic brain inju dementia with beha mood disorder, sch During observation LPN-C went into R4 change around the and removed the d blood tinged draina gloves, the LPN op packaged supplies, handles to the close containing oral toot leaning against the gloves on, the LPN use a Q-tip to clear stoma area. Sligh on the Q-tip. LPN-C and feeding syringe snapped the extens checked for patence attempting to admin	d on 12/26/2013 with om the care plan) that alopathy, dysphagia, history of iry, post traumatic seizures, avioral disturbances, episodic nizophrenia, and CVA (stroke). s, on 3/11/2014 at 9:20 a.m., 45's room to do a dressing gastric tube. LPN-C gloved ressing which had a tiny bit of tige on it. Without changing bened drawers and touched , the resident's chair, door et, a blood pressure cuff, bag hettes, and a mat which was closet. Keeping the same took water from a pitcher and n around the gastric tube t pinkish drainage was noted C then touched the medication e and tube extension. LPN-C sion on the gastric tube and cy using a stethoscope. When nister water, the water did not to use the stethoscope again					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	· · · · · · · · · · · · · · · · · · ·		С
		00989	B. WING			13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 55021			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	age 40	21390			
	gloved and put the	gauze around the stoma.				
	nursing (DON) was infection control pro- dressing change to DON stated the nur- standard precaution for dressing change was requested and A policy for Dressin revised 6/2013 was Place supplies on of Apply clean gloves, and dispose of in b hands. 12. Apply cl per physician order to outer boarders u most contamination do not touch other bedding, etc., and r contaminate the wo cleaning supplies in	:00 a.m., the director of interviewed regarding lack of ocedures used with R45's the gastric tube site. The rse's should be following ns and also the facility policy es that are not sterile. A policy provided by the facility. ag-Non-sterile Treatment a reviewed. It identified: "6. clean field. 7. Wash hands. 8. . 11. Remove soiled dressing ag. Remove gloves. Wash ean gloves. 13. Clean wound s. Cleanse wound from center sing a circular motion (area of n to area of least). Ensure you skin surfaces, furniture, return to wound bed as this wil bund bed. 14. Dispose of n bag. 15. Remove gloves and .pply clean gloves. 17. Apply d."				
	aureous (MRSA) w	y methicillin resistant staph vith a tracheostomy and ecautions were not consistently	/			
	of present illness: chronic tracheostor shortness of breath	ated 3/5/2014 identified history Respiratory: Patient with my and with increased cough a and sputum culture showed monas and started on IV				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00989	B. WING	B. WING		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
FARIBAL	JLT CARE CENTER		LETT AVENUE	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	ae 41	21390	DEHOLING	,,,,		
		ent for bronchopneumonia: a with sputum with					
	closed. A note to c the wall at the door	20 p.m. R48's room door was heck at nurse's station was on way. A plastic cupboard at the gowns, gloves, masks, red pressure cuff and					
	ambulating in the h mask over a trach s medication cart wai a.m., R48 was obse with the mask off th practical nurse (LP trach site and tells because of an infec stated the resident respiratory methicil (mrsa). LPN-C gloo stated she didn't go didn't spit. She woo in the air and cough was not good abou LPN went into the r resident out of the h the mask off the tra bed. At 9:47 a.m., with a mask over th medication cart. Th walker to redirect th	00 a.m. R48 was observed all with a walker and had a site and then stood at the iting for medications. At 9:00 erved to come out of the room he trach site. A licensed N)-C puts a mask over the the resident it needed to be on ction the resident had. LPN-C was on precautions related to lin resistant staph aureos ved and put a mask on and own because the resident re a mask because of droplets hing from the trach and R48 t leaving a mask on. The esident room and assisted the pathroom. The resident took ach and sat on the edge of the R48 came out of the room he trach and stands by the he LPN touched the resident's he resident away from the cart					
	to set up medicatio removed the mask basket on the cart b	eansing her hands continued ns. At 10:00 a.m., R48 and threw it on top of a waste but it just laid on top of the blied a new mask and					

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	ta Department of He		()/o:	00107010700			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:	· · · · · · · · · · · · · · · · · · ·		-	
		00989	B. WING	B. WING		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	JLT CARE CENTER	1738 HU	LETT AVENUE	NORTH			
FANIDA	DEI CARE CENTER	FARIBAU	JLT, MN 5502 ⁻	1			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT		(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE	
				DEFICIENC	Y)		
21390	Continued From pa	age 42	21390				
	continued to set up	the medication without					
	washing her hands						
		me ambulating out from room					
		hout a mask over the trach.					
		n is the second door down the					
		dent walks a distance to get to					
		The nurse saw the resident					
	and got a mask.						
	On 3/11/2014 at 10	:00 a.m., R48 walked into the					
		stood over NA-K who tried to					
		t back to his room since the					
	tracheostomy was	not covered.					
	$O_{2} = 2/10/0014$ at 7:	45 cm D40 was shown ad up					
		45 a.m., R48 was observed up e's desk, however, had a mask					
		45 a.m., R48 was observed					
		allway with walker and no					
		ried to redirect the resident,					
		, and continued to set up					
		t washing hands, while the					
		e. LPN-C indicated she didn't					
		room but just a mask and					
		e resident didn't cough or spray	/				
		n during suctioning because the tube and there is no spray					
		n., LPN-C entered the room					
		ves on. There were no gowns					
		tside the room. The resident is					
	already laying in be	ed. The LPN pulled on the					
		ad under the resident, moved					
		, touched the linens and then					
		lead. With her gloves still on,					
		with the controls. Without					
		PN-C removed the mask over					
		, touched the dressing around removed the inner cannula					
		n the wastebasket. Then					
		l gloves (had mucous on them)					
		LPN Opened up the new					
inesota D	epartment of Health	· ·	p l			1	

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _	·····			
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
ARIBA	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]				
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21390	Continued From pa	ige 43	21390				
	With the gloves still neb medication into and started it up an over the trach. She and dated it, poured the resident clothing tube. Went into he then removed the ti extension on the fe syringe in the tubing stethoscope to che retrieved 2 cans of in the room, while h without a cap on it is changing gloves, on puts the syringe into tube feeding and gi medications and wa the LPN then unhor recapped the syring gloves, she touched the tube feeding an dressing to the tube have any soap in the indicated she had se cart. When checked cart and another sta 3:15 p.m., R48 had several times, how mask on over the tr On 3/12/2014 at 10 did not change her throughout the proof On 3/12/2014 at 12 R48's room without	:30 a.m., LPN-C verified she gloves appropriately	e f				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00989	B. WING	B. WING		C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FARIBA	JLT CARE CENTER		LETT AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	SHOULD BE	(X5) COMPLETE DATE
21390	bed and straightener resident had a mas to cough. When the bathroom to wash h was no soap in the soiled utility room to doors down from th the housekeeper th soap and the house dispenser. On 3/12/2014 at 12 (NA)/medical record walked into R48's re or gown on. The ai the room and touch on the back. The re get into bed. The a washing her hands, mask and went in to NA-F was interview of a mask over the nurse aides put a m do cares on the res out of the room, the the room and encou mask on or they do resident was indepe washing own hands On 3/13/2014 at 6:2 in R48's room sucti resident was cough mask but had glove available in the cab door. At 8:30 a.m., without a mask on a walk by the residen	ed it out touching linens. The k over the trach but was noted e LPN-J went into the ner hands she noted there dispenser. She went to the o wash her hands. It was 2 e resident's room. LPN-J told e resident's bathroom needed ekeeper went in and filled the :49 p.m., a nurse aide ds (MR) (NA)-K/(MR)-K com without a mask, or gloves de directed the resident into ed the walker and the resident sident wanted assistance to ide walked out without NA-F put her gloves on and o assist the resident into bed. ed about the resident and use trach area. She indicated the nask over the trach when they ident. If they see R48 come ey redirect the resident to put a it for the resident. The endent with toileting and				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		BERTH TO/THOMBER.	A. BUILDING: _	·····			
		00989	B. WING			C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE	
21390	Continued From pa	ge 45	21390				
	nursing (DON) was isolation precaution stated masks, glove when doing cares. precautions becaus culture for MRSA re DON on observatio glove exchange, lac lack of gowns in the observations of res mask and sometim times not. The DO following the precau	1:00 a.m., the director of interviewed regarding the as to be used for R48. She es, gowns are to be worn R48 was placed on se the resident had a positive espiratory. Interviewed the ns of poor handwashing and ck of soap in the bathroom, e cupboard and also discussed ident leaving room without a es being directed and other N indicated the staff should be utions because the resident RSA and the precautions were					
		noon, a green droplet s placed at the doorway of the					
	nursing station and minutes until RN-A	00 p.m., R48 walked into the stood over RN-A for several was able to direct R48 back to cheostomy was not covered.)				
	(RN)-A was intervie problem coming ou	00 p.m., a registered nurse ewed. and verified R48 had a t to the desk area and in the eping the trach area covered ty protocol.					
	interviewed regardi procedures. She si keep him in isolatio precaution, but he c	30 p.m., the DON was again ng infection control tated "[R48], we are unable to n so he is in what we call does not follow through with constantly taking him to his					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
						С	
		00989	B. WING		03/	03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]	-			
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21390	Continued From pa	age 46	21390				
	room and reapplyir (tracheostomy)."	ng the masks to cover the trach	1				
	NEBULIZER EQUI SANITIZED BETW						
	at 10:15 a.m. to be The nebulizer cup a machine. The nebu	stem was observed on 3/12/14 located on his bed side stand and tubing was attached to the lizer cup where the medication ed with moisture drops on the					
	interviewed on 3/12 that she had set up medication treatme LPN-B had not clea the inhalation treat	nurse (LPN)-B was 2/14 at 10:15 a.m. and said and given R10 his nebulizer ent at 8:00 a.m. However, aned the equipment following ment to prevent bacterial <i>t</i> th as outlined in the facility					
	was noted to be ful there was a white f the nebulizer cup. (and care of the neb R10 said, "They [re ever clean it." R10	t 1/17 p.m. R10's nebulizer ly connected and this time ilm coating the entire inside of On asking R10 about the use pulizer equipment at this time ferring to facility staff] don't said that he had used the nt earlier in the day and no one e then.					
	assistant (TMA)-A cleaning of R10's n the inhalation treati equipment is to be	p.m. trained medication was asked about the use and lebulizer equipment following ment. TMA-A said that the taken apart and the cup is to and the equipment is to air dry.					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			С
		00989	B. WING			13/2014
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 55021	-		
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21390	Continued From pa	age 47	21390			
		not been done following R10's It on 3/12/14 8:00 a.m. dose r 8:00 a.m. dose.				
	of following the faci nebulizer equipmer	sing was made aware of lack ility policy on the care of the nt on 3/13/14 at 2:47 p.m. and d for the policy in regards to ation procedure.				
	Nebulizer Procedur "11. Administer the depleted (about 10 Disassemble devic and nebulizer cup v	ert Health Group Small Volume res, revised date 06/2013 read rapy until the medication is -15 minutes)." and "13. e and rinse the mouthpiece with water and dry. Store unit bispose of equipment per				
	The director of nurs assure that policies that staff are traine procedures are imp	THOD OF CORRECTION: sing and or designee could and procedures are current, d and monitored to assure blemented to prevent the when caring for residents.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21510	MN Rule 4658.120 SpecializedRehabil	0 Subp. 2 A.B. itative Services; Provision	21510			
	rehabilitative servic resident's compreh nursing home mus	of services. If specialized es are required in the ensive plan of care, the t: uired services; or obtain the				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FARIBAL	JLT CARE CENTER		LETT AVENUE ULT, MN 5502 ⁻¹				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21510	Continued From pa	age 48	21510				
	required services fi according to part 4	rom an outside source 658.0075.					
	by: Based on interview	ent is not met as evidenced and document review the vide rehabilitative services as					
	necessary for 1 of	1 resident (R46) reviewed.					
	Findings include:						
	R46 lacked a refermed	ral for rehabilitation services.					
	hospital to the facili R46's diagnoses lis screening dated 11 (alcohol induced de The care plan print diagnoses as alcoh	on 11/5/13 from an acute care ity's locked dementia unit. sted on the preadmission /5/13 at Karsakoff dementia ementia) and bipolar disease. ed 2/18/14 identified R46's nol induced dementia, bipolar ependence, drunkenness, patitis.					
	11/12/13 and the quindicated R46 had status (BIMS) score impairment, display	imum Data Set (MDS) dated uarterly MDS dated 1/12/14 a brief interview for mental e of 13/15 or no cognitive yed no behaviors, was ctivities of independent living.					
	stated was admitte abuse and had not program. R46 stat outpatient services community, but had	v on 3/10/14 at 5:13 p.m. R46 d with a diagnosis of alcohol been involved in a treatment ed he had investigated , found some available in this d not been provided access to I he would be willing to do ent treatment.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00989	B. WING			C 13/2014
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAU	ILT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻			
(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 AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21510	Continued From pa	age 49	21510			
	facility or a facility w The care plan print resident's history w treatment was not w During an interview director of nursing	vould like to be in a treatment where people are younger." red 2/18/14 was reviewed. The rith alcohol and request for noted. v on 3/13/14 at 12:10 p.m. the (DON) stated she thought s working on the treatment				
	interviewed on 3/13 R46 had discussed treatment as outpat she had contacted guardian did not wat because guardian wat able to return to the she had also discus case manager and needed to get the g the management to not hold the bed for inpatient treatment if a readmission be stated she had not outpatient treatment to find any social se	designee (SSD) was 3/14 at 12:57 p.m. SSD stated 4 with her the request of tient or inpatient. SSD stated the ant R46 to go to treatment was afraid R46 would not be e nursing home. SSD stated ssed treatment with the county that he had said the facility guardian on board. SSD stated eam stated the facility would r return following the 90-day program so SSD did not know ed would be available. SSD investigated further for nt. SSD stated she was unable ervices documentation from rker related to treatment				
	The director of nurs monitor to assure t	THOD OF CORRECTION: sing and or designee could hat residents are assessed propriate rehab services as				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00989	B. WING	B. WING		C 13/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
	JLT CARE CENTER		LETT AVENUE			
ANIDAU	JEI CARE CENTER	FARIBAU	JLT, MN 55021	l		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE
21510	Continued From pa	age 50	21510			
	(21) days.					
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	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 reside adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, t review to the Qualit (QAA) committee re the attending phys the consulting phar directly to the QAA.		9			
	by: Based on observat review, the facility f for use and failed to as needed psycho-	ent is not met as evidenced ion, interview, and document ailed to develop parameters o monitor the effectiveness of active medications for 2 of 5 0) reviewed for unnecessary				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST	ATE, ZIP CODE			
ARIBA	JLT CARE CENTER		LETT AVENUE JLT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21540	Continued From pa	ge 51	21540				
	parameters for use effectiveness when non-pharmacologic multiple scheduled without adequate m R27 was admitted to (from care plan) alt amputation of toes, dependence, nonded diabetes, hypertens type dependence a disorder, drug-indu- hallucinations, para A physician order do on Clonazepam 0.5 severe anxiety. Th psychoactive medic Zyprexa, and Trilafo Medication sheets of reviewed. The resis clonazepam (antiar times in both month psychotropic medic) The target behavior monitored included indicators, hearing objects not there, a direction, and paci documented on ever analysis of the behavior needed antianxiety	used, and without use of al interventions; and was on psychotropic medications nonitoring . to the facility 2/3/2014 with dx ered mental status, traumatic sedative/hypnotic /anxiolytic ependent cannabis abuse, sion, esophageal reflux, opioid buse, dissociative identity ced psychotic disorder with moid schizophrenia, ated 2/3/2014 identified R27 5 mg twice daily as needed for e other scheduled cations were Buspar, Elavil,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00989	B. WING			C 13/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 52	21540			
	R27's care plan initiated 2/5/2014 and print date of 2/20/2014 was reviewed. The use of the as necessary and scheduled psychotropic medications with interventions was not addressed.					
	interviewed regardi medication. DON s documenting in the effectiveness. The pharmacological in use. The document MAR or record and On 3/13/2014 at 12 DON was interview summary/analysis of identify effectiveness and use of the as m She indicated no an	of the behavioral data to ss of the scheduled medicatior leeded antianxiety medication. nalysis was done of the o criteria for the use of the as				
	sleep and anxiety v monitoring of effect	ed antianxiety medication for vithout criteria for use, tiveness and lack of use of cal interventions prior to				
	1/9/2014 identified	ary from the hospital dated R40 used as needed iety and every bedtime for				
	schizoactive disord	l with diagnoses hx of falls, er,paralysis agitans, iin, parkinson's disease, hx of				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00989	B. WING		C 03/13/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 55021				
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21540	Continued From pa	age 53	21540				
		erebral hemmorrhage, ephalus, insomnia. (on MD					
	Lorazepam 0.5 mg needed for anxiety;	lated 1/16/2014 identified by mouth every 6 hours as and Lorazepam 0.5 mg (4 nouth at bedtime as needed for					
	Lorazepam (antian necessary for sleep	dication sheets were reviewed xiety medication) was used as and/or anxiety: 1/149 sed 23 times and in 3/14-it					
	reviewed. It identifie staying asleep; rela history of taking sle to bedtime. An ave hours. R40 had ne Parkinson's diseas environmental factor sleeping difficulties assessment was a	dated 1/13/2014 was ed the resident had difficulty ated to pain; did not have a eep medications routinely prior rage length of nap was 1-2 eurological deficits (stroke, e, seizure disorder). No ors contributing to resident was identified. The collection of data but did not or analysis of the data to					
	and print out date o	h initiated date of 1/14/2014 of 2/20/2014 was reviewed. It 0's sleep issues or use of as medications with					
	assistant (TMA)-C	:45 a.m., a trained medical was interviewed regarding use nedication. TMA-C indicated					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING	A. BUILDING:		С	
		00989	B. WING			13/2014	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21540	Continued From pa	ge 54	21540				
	and indicated R40 night for sleep. The rarely used it throug resident was up an	e medication during the day was given the medication at e resident got anxious but ghout the day because the d about. The TMA did not riteria to use prior to giving the)				
	DON was interview antianxiety medicat be using non pharm to administering the following up also fo indicated she just of 2/17/2014. She als monitoring and indi DON verified they of	1:50 p.m. and 1:05 p.m., the ed regarding criteria for use of ion. DON stated they should nacological interventions prior e medication and should be r effectiveness. The DON lid an education on that on so checked for R40 re: sleep cated it was not being done. did not analyze the sleep o come up with a plan.	f				
	The director of nurs assure that policies and that staff trainin assure each reside	HOD OF CORRECTION: sing and or designee could and procedures are updated ing has been completed to ent's drug regimen is residents are not taking					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One					
21685		5 Subp. 2 Plant eration, & Maintenance	21685				
		plant. The physical plant, prs, ceilings, all furnishings,					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00989	B. WING			C 13/2014
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			10/2014
FARIBAU	JLT CARE CENTER	FARIBAL	JLT, MN 5502 ⁻	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21685	Continued From pa	age 55	21685			
	continuous state of with regard to the h well-being of the r	pment must be kept in a f good repair and operation nealth, comfort, safety, and esidents according to a written ce and repair program.				
	This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to keep kitchen equipment and the kitchen environment clean and sanitary, also failed to keep the physical environment free from foul odors.					
	Finding include:					
		tour with Cook-A and Cook-B p.m. the following was				
	kitchen had a thick and when the grill the entire top of the The ice machine lo observed to have t coat of dust/debris	nd refrigerators located in the layer of dust covering the grill was moved the dust covered e pieced of equipment. Dicated in the dining room was he grill covered with a thick and the reusable filter was powder type debris.				
	scattered around the electrical cords and appliances includin coated with a thick emergency pull ring	chen had multiple food debris he perimeter of the room. The d water tubing connected to the ng the coffee maker was layer of dust/debris. The metal g located near the coffee strands of dust/debris.				
		mental tour on 3/13/14 at 8:30 by the director of maintenance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
FARIBAU	ILT CARE CENTER		LETT AVENUE JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	ge 56	21685			
	and lead housekee observed:	per. The following was				
	odor present and the the odor continued housekeeper said it do clean in the bath smell continues to b The 300 wing was of equipment including resident lifts lined d hallway. Also the m west side of the hal residents who met opposite directions into an open door w pass them by. With used to store reside who are ambulatory the hand rails on th asking the mainten housekeeper it was the west side of the equipment because the area to keep the the maintenance di this practice of keep stored on the west a long time.	t sometimes smells and they proom. However, the urine be present. bbserved to have resident use g wheel chair, weight chair, own the west side of the edication cart is placed on the lway. There were two each other going in the and one of them had to move vay to allow the other resident the west side of the hallway ent equipment the residents y do not have free access to e west side to the hallway. On ance director and learned that they have to use 300 wing to store resident e there is no storage room in em. It was also learned from rector and housekeeper that oing resident equipment hallway has been practiced for				
	The director of nurs and/or designee co	HOD OF CORRECTION: sing, director of maintenence uld assure the physical plant, rs, ceilings, all furnishings, ment in kent in a continuous				

Minnesota Department of Health STATE FORM

477C11

If continuation sheet 57 of 79

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	СОМ	E SURVEY PLETED
		00989	B. WING	WING		13/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	ge 57	21685			
	residents according maintenance and re					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			
	residents shall have medical and person needs. Appropriate care designed to er highest level of phy This right is limited	iate health care. Patients and the right to appropriate thal care based on individual e care for residents means thable residents to achieve their sical and mental functioning. where the service is not blic or private resources.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure the use of aides for 1 of 2 residents (R4) ing aides.				
	Findings include:					
	7:00 p.m. R4 was c able to hear despite present in the left e the missing hearing not know what the f or replacing the hea NA-B came into the	and interview on 3/10/14, at omplaining about not being having a hearing aide ar. R4 said she had reported aide to her right ear, but did acility was doing about finding aring aide. Nursing assistant room and when questioned happened to the hearing aide				

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ROVIDER OR SUPPLIER	00989				
		B. WING		C 03/13/2014	
T CARE CENTER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		LETT AVENUE JLT, MN 55021			
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 58	21810			
When asked how of shrugged shoulder work, I'm used to h attempted to chang could not hear the typed out on the co answer questions. During an observat R4 was on her way not have her hearing designee (SSD) wa hearing aides and of concern form and v aide was missing. A found the hearing a and put them in R4 they are working ju At 3:00 p.m. R4 wa is not the new one, are my old hearing not able to hear su verified she did not missing and though week. R4's active diagnos (MDS) form dated to cerebral vascula attack, thyroid dise ears.	lo you communicate NA-B s and stated, "We make it er." The nursing assistant ge the battery for R4 but R4 conversation which surveyor imputer for R4 to read and ion on 3/13/14, at 11:50 a.m., to the beauty shop and did ng aides in. The social service as questioned about the did not have a missing item or was not aware the right hearing About 1 p.m. the SSD said she aides in the medication cart 's ears and she can hear now, st fine. is interviewed and stated, "This (pointing to right ear) these aides that don't work." R4 was rveyor. Interview with RN-A know the hearing aide was at R4 had the hearing aide last is from the minimum Data Set 12/29/13, lists but is not limited r accident, transient ischemic ase, and hearing loss both				
dated 12/30/13, inc out of a possible 15	licated a summary score of 9 5 for cognitive patterns				
oververte Effordefiet Aiservrv F(tee Fooii F	or why the one in the When asked how of shrugged shoulders work, I'm used to hattempted to change could not hear the of yped out on the co- answer questions. During an observate A4 was on her way not have her hearing designee (SSD) was hearing aides and of concern form and was and put them in R4 hey are working ju At 3:00 p.m. R4 was not the new one, are my old hearing not able to hear sur- verified she did not nissing and though veek. R4's active diagnos MDS) form dated o cerebral vascula attack, thyroid dise ears. R4's Brief Interview dated 12/30/13, inco- put of a possible 15 ndicating moderate	During an observation on 3/13/14, at 11:50 a.m., R4 was on her way to the beauty shop and did not have her hearing aides in. The social service besignee (SSD) was questioned about the nearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she ound the hearing aides in the medication cart and put them in R4's ears and she can hear now, hey are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A verified she did not know the hearing aide was nissing and thought R4 had the hearing aide last veek. R4's active diagnosis from the minimum Data Set MDS) form dated 12/29/13, lists but is not limited to cerebral vascular accident, transient ischemic attack, thyroid disease, and hearing loss both ears. R4's Brief Interview for Mental Status (BIMS) dated 12/30/13, indicated a summary score of 9 but of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "I	by the one in the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant attempted to change the battery for R4 but R4 could not hear the conversation which surveyor yped out on the computer for R4 to read and answer questions. During an observation on 3/13/14, at 11:50 a.m., R4 was on her way to the beauty shop and did not have her hearing aides in. The social service designee (SSD) was questioned about the nearing aides and did not have a missing item or concern form and was not aware the right hearing aide was missing. About 1 p.m. the SSD said she ound the hearing aides in the medication cart and put them in R4's ears and she can hear now, hey are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was not able to hear surveyor. Interview with RN-A rerified she did not know the hearing aide was nissing and thought R4 had the hearing aide last week. R4's active diagnosis from the minimum Data Set MDS) form dated 12/29/13, lists but is not limited o cerebral vascular accident, transient ischemic titack, thyroid disease, and hearing loss both pars. R4's Brief Interview for Mental Status (BIMS) lated 12/30/13, indicated a summary score of 9 but of a possible 15 for cognitive patterns indicating moderate impairment. R4's plan of care dated 12/3/13, directed staff, "I	A short of the left ear was not working. When asked how do you communicate NA-B shrugged shoulders and stated, "We make it work, i'm used to her." The nursing assistant tittempted to change the battery for R4 but R4 bould not hear the conversation which surveyor yped out on the computer for R4 to read and inswer questions. During an observation on 3/13/14, at 11:50 a.m., R4 was on her way to the beauty shop and did to thave her hearing aides in. The social service lesignee (SSD) was questioned about the nearing aides and did not have a missing item or soncern form and was not aware the right hearing bide was missing. About 1 p.m. the SSD said she ound the hearing aides in the medication cart and put them in R4's ears and she can hear now, hey are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This is not the new one, (pointing to right ear) these are my old hearing aides that don't work." R4 was tot able to hear surveyor. Interview with RN-A rerified she did not know the hearing aide last week. At's active diagnosis from the minimum Data Set MDS) form dated 12/29/13, lists but is not limited o cerebral vascular accident, transient ischemic titack, thyroid disease, and hearing loss both sars. At's Brief Interview for Mental Status (BIMS) lated 12/20/13, indicated a summary score of 9 but of a possible 15 for cognitive patterns ndicating moderate impairment. At's plan of care dated 12/3/13, directed staff, "I	A solution of the left ear was not working. When asked how do you communicate NA-B thrugged shoulders and stated, "We make it work, I'm used to her." The nursing assistant tittempted to change the battery for R4 but R4 sould not hear the conversation which surveyor yped out on the computer for R4 to read and inswer questions. During an observation on 3/13/14, at 11:50 a.m., 44 was on her way to the beauty shop and did ot have her hearing aides in. The social service lesignee (SSD) was questioned about the nearing aides and did not have a missing item or soncern form and was not aware the right hearing ide was missing. About 1 p.m. the SSD said she ound the hearing aides in the medication cart ind put them in R4's ears and she can hear now, hey are working just fine. At 3:00 p.m. R4 was interviewed and stated, "This s not the new one, (pointing to right ear) these rer my old hearing aides that don't work." R4 was tot able to hear surveyor. Interview with RN-A rerified she did not know the hearing aide last week. At's active diagnosis from the minimum Data Set MDS) form dated 12/29/13, lists but is not limited o cerebral vascular accident, transient ischemic tatack, thyroid disease, and hearing loss both ars. At's Brief Interview for Mental Status (BIMS) lated 12/30/13, indicated a summary score of 9 but of a possible 15 for cognitive patterns ndicating moderate impairment. At's plan of care dated 12/3/13, directed staff, "I

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		A. BUILDING:				С	
		00989	B. WING			03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
FARIBA	ULT CARE CENTER		ETT AVENUE LT, MN 55021				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21810	Continued From pa	ige 59	21810				
	of hearing. Make ca aides prior to the st Furthermore, the pl read, "I have extensi impaired communic impairment." The i hearing aids left in taken to the nurses educated me on the keeping them locket theft policies of the aids. I can put them independently. I wil especially with takin on the plan of care again attempted to aides kept in nurse Resident rejected ti losing hearing aidea anything from resid assuring hearing ai The consultation re 7/16/13, under reco plan from nursing h hearing aids will be with replacement. F aide fitting." The co audiology dated 9/3 wearing both aides	lan of care revised 7/10/13, sive hearing loss. Potential for					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21810	Continued From pa	ge 60	21810			
		aced in both hearing aids. The d. Both hearing aides are				
	for March 2014, the the tracking of the k nursing assistant a "Hearing Aides." bu size for which ear, the	dication and treatment sheets ere was no area addressing bilateral hearing aides. The ssignment sheet read, it did not designate the battery nor did the assignment sheet unt for the hearing aides.				
	unsuccessful to dis the medical record family was difficult answering machine	resident family were cuss the hearing aides and director (MRD) validated the to get hold of as neither had es or message capabilities. now if the family was aware of de being missing.				
	The facility could as are updated, implei and that based on i personal care base provided to enable	THOD OF CORRECTION: ssure that policies, procedures mented, evaluated, monitored ndividual assessments, d on individual needs is residents to achieve their sical and mental functioning				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21855	MN St. Statute 144 Residents of HC Fa	.651 Subd. 15 Patients & ac.Bill of Rights	21855			
	residents shall have	nent privacy. Patients and e the right to respectfulness lates to their medical and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:	·····			
		00989	B. WING			C 3/13/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21855	Continued From pa	age 61	21855				
	consultation, exam confidential and sh Privacy shall be res bathing, and other	ram. Case discussion, ination, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene, for patient or resident safety or					
	by: Based on observat review the facility fa privacy during care observed for incom	ient is not met as evidenced ion, interview and document ailed to ensure personal is for 1 of 3 residents (R25) tinence and the facility failed to personal information for 1 of 4 served smoking.					
	Findings include:						
	R25 lacked privacy	v during incontinence cares.					
		v on 3/11/14 at 9:12 a.m. R25 pull curtains or close doors to ring cares.					
	provided by nursing medication aide (T 1:30 p.m. and 1:50 was observed to un TMA-E was observed the room without p providing personal in bed exposed. The again. No privacy	during incontinence cares g assistant (NA)-J and trained MA)-E on 3/12/14 between p.m. During the cares R25 rinate on the bed linens. yed to open the door and leave ulling the privacy curtain or privacy to R25 who was lying MA-E reentered the room curtain was pulled and no as provided to R25.					
		ewed at 1:50 p.m. and stated should have been pulled					

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00989	B. WING	B. WING		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502				
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21855	Continued From pa	age 62	21855				
	before she exited the	he room.					
		v on 3/13/14 at 11:45 a.m. the stated privacy was an e.					
	R46 lacked confide information.	R46 lacked confidentiality of personal smoking information.					
	posted in the nursir activity area that st typing] Smoking Sc	p.m. a sign was observed ng area/dining room/resident ated [R46's name in bold chedule. The sign listed the f cigarettes R46 could smoke					
		v on 3/10/14 at 5:11 p.m. R46 es were locked up and felt way.					
	3/13/14 at 7:35 a.m	on 3/12/14 at 7:10 p.m., on n. outside to smoke under staff time R46 was observed to ask smoke.					
	completed a smoki stated the resident cognitive loss, and in bedroom or bath risk assessment da smoking, "will jump	nts identified the facility ing assessment on 2/6/14 that required supervision, had had been observed smoking room. The facility elopement ated 2/6/14 noted under p fence if given a chance". No sis of data was provided.					
pagasta D	focus related to sm directed the resider	plan printed, 2/18/14, had a oking The interventions nt required visual supervision t cigarettes and lighter were to					

Minnesota Department of Health STATE FORM

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Minneso	ta Department of He	alth			FONIV	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAU	ILT CARE CENTER		LETT AVENUE JLT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 63	21855			
	director of nursing (R46 had smoking is schedule had been had wanted to go o and needed superv risk. DON stated th schedule in a public SUGGESTED MET The facility could as procedures are revi conducted to assum- privacy during cares information regardin	on 3/13/14 at 12:10 p.m. the DON) stated she was aware sues and that a smoking implemented because R46 utside to smoke frequently ision because of elopement he posting of the smoking c area was a dignity issue. THOD OF CORRECTION: sure that policies and ewed and that staff training is e residents have personal s and that personal ng the resident is kept posted for everyone to see.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			
	shall be encouraged their stay in a facility to understand and e patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, lischarge. Notice of the e of the facility or program, as and telephone numbers for the cility Complaints and the area	,			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: B. WING		С	
		00989			03/13/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FARIBAU	ILT CARE CENTER		ETT AVENUE LT, MN 5502 ⁻			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21880	Continued From pa	age 64	21880			
	nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.					
	residential program 253C.01, every non facility employing in provides outpatient have a written inte at a minimum, sets followed; specifies limits for facility resi- or resident to have advocate; requires grievances; and pro- an impartial decision otherwise resolved residential program 253C.01 which are treatment program centers with section health maintenance 62D.11 is deemed	e inpatient facility, every m as defined in section nacute care facility, and every nore than two people that t mental health services shall strinal grievance procedure that, a forth the process to be time limits, including time sponse; provides for the patient e the assistance of an a written response to written ovides for a timely decision by on maker if the grievance is not . Compliance by hospitals, ms as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the written internal grievance				
	by: Based on interview facility failed to act related to answerin 43 residents (R12,	ent is not met as evidenced and document review, the upon resident grievances og of the call lights for 6 of the , R2, R31, R53, R58, R28) who ty who expressed concern with swered.				
	Findings include:					

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If continuation sheet 65 of 79

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONTLETION		A. BUILDING:		-	
		00989	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET
21880	Continued From pa	age 65	21880			
	at 5:00 p.m., "I thin respect and dignity here." When asked "I have heard the s and I have complai treated, but they do the resident counci about the problems the staff are verbal talked about anothe call light on and it w by the doorway and was trying to get th "Not now! Better be oxygen hose becau referred to the staff what do you want? yourself! R12 referred defensive with her on the name tags. situations to the resishould be criteria in have talked to and They don't follow th confident staff are p Review of R12's Br (BIMS) dated 12/11 score of 13 out of a patterns indicating The resident counci- reviewed and docu (1) 3/6/14, several were brought up su coming into the root then leave and don	il meeting minutes were mentation included: concerns regarding call lights ich as R12 expressing staff om, whip off the call light and				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00989	B. WING		C 03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FARIBA	ULT CARE CENTER		ETT AVENUE LT, MN 55021	-		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21880	and shut it off and s have someone else happens more than on for a half hour to R31 said, call lights the evening. R58 was concerned toilet so long. (2) 2/6/14, concerns meal times and call according to R2, R1 (3) 1/2/14, R31 Why response time R31 answered, so few,(t minutes. Meal times answer lights. R53 agreed and co hour. R13 expressed Sta want to throw you to some cares require (4) 12/5/13, R53 co to forty five mnutes R28 referred to issu p.m. R12 referred to a re the bell, she didn't h R31 said half the tin assistants) are not TMA (trained medic Documentation was concerns recomme resident council me	say they will be back, they to take care of, and this once, I can have my call light o an hour. are generally worse during d about having to wait on the s were expressed regarding lights continue to be an issue I2 and R31. en asked about the call light expressed, will they ever be two) people working, takes 40 s there is no one around to mmented Yes, takes half an ff needs to slow down, they begether and get out of there, more time mmented it took half an hour to answer the call light. ues with call lights after 2:00 esident who was yelling out for nave her call light near her. me the CNA (certified nursing reporting my request to the cation aide). s lacking to indicate the ndations expressed during the eetings had been acted upon the residents to assure the	21880	DEFICIENC	τ,	

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·	COMIN LETED	
		00989	B. WING		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
		1738 HUI	ETT AVENUE	NORTH		
AKIBAU	JLT CARE CENTER	FARIBAL	ILT, MN 55021	l		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLET DATE
IAG			IAG	DEFICIENC		
21880	Continued From pa	ae 67	21880			
	-	-				
		During interview on 3/13/14, at 9:15 a.m. with the				
) it was confirmed that				
		expressed at resident council				
		documented on a grievance				
		nent involved. Call lights would				
	be the director of nursing (DON)responsibility although all staff were responsible to answer					
	resident call lights. The AD passes the meeting					
		epartment heads and they are				
		nce form. The DON had				
		nber and January resident				
		nd informed residents audits				
		were being conducted of the resident call light				
		d that a memo was posted to				
		not attend the February and				
		ncil meetings but answered				
		ns of the call lights not being				
		referring to the audits that				
		a memo being posted to the				
		wering call lights. The AD				
	verified the residen	ts continiued to express				
		h the answering of the call				
	lights and were bec	coming increasingly frustrated				
	because answering	of the call lights has been a				
	concern for many n	nonths.				
	During an interview	on 3/13/14, at 8:30 a.m. with				
		ent council and concerns				
		ent council, she stated, " I put				
		y shut it off mostly on the				
		are short of help all the time,				
		d say we gotta go now, you get				
		er expounded on concerns				
		resident council and stated,				
		ues to happen, why can they				
		ave incontinence, I have been				
		to help me. I have pooped in				
		hs ago waiting for someone to				
	come. Now mave i	earned to call on the phone to				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00989	B. WING		C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S ⁻			
FARIBAL	JLT CARE CENTER		.ETT AVENUE LT, MN 5502 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21880	Continued From pa	ge 68	21880			
	what is happening v	with my complaints."				
	Mental Status (BIM summary score of	of R2's Brief Interview for S) dated 1/20/14, indicated a I5 out of a possible 15 for ndicating cognitively intact.				
	administrator was u documentation to v concerns expressed follow up discussed	on 3/13/14, at 1:30 p.m. the inable to produce any alidate the resident specific d were investigated and/or a l to their satisfaction with the histrator stated, "We have e process."				
	The director of nurs assure residents gr	HOD OF CORRECTION: sing and or designee could ievances are listened to, acted ts are reported back to the				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21990	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4 Reporting - Inerable Adults	21990			
	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify the caregiver, the nature	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient ne vulnerable adult, the re and extent of the suspected evidence of previous				

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	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00989	B. WING	B. WING		13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FARIBA	ULT CARE CENTER		LETT AVENUE JLT, MN 55021	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From par maltreatment, the m reporter, the time, c incident, and any of reporter believes m the suspected malti reporter may disclo in section 13.02, an section 144.335, to comply with this sul This MN Requireme by: Based on observati review the facility far of potential abuse w and immediately re 6 of 8 residents (R1 the sample who rep addition, the facility residents were prot while an investigation Findings include: R12, R1, R70, R16 allegation of potent to thoroughly invest the resident from poinvestigation was point the allegation to the R12, during an initia 3/10/14, at 5:00 p.m need better training consider to be abus further explain R12 yell at the lady next myself about how I	ge 69 hame and address of the late, and location of the ther information that the ight be helpful in investigating reatment. A mandated se not public data, as defined id medical records under the extent necessary to odivision. The extent necessary to odivision.	21990			

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00989	B. WING			C 03/13/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
FARIBAL	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE	
21990	Continued From pa	ge 70	21990				
	abusive and rude." situation when she taking awhile so sh two staff walked by attention one of the careful, I will cut off know how to do it." making comments You should be able to the staff as gettir cannot see the nan said she had report council, and there s you know who you will follow through. R12 stated not beir on the information.	w through, the staff are verbally R12 talked about another had the call light on and it was e stood by the doorway and as R12 was trying to get their m said "Not now! Better be your oxygen hose because I R12 referred to the staff like, "Yah, what do you want? to do it yourself!" R12 referred ng defensive with her but she hes on the name tags. R12 red situations to the resident should be criteria in place so have talked to and so people They don't follow through and ng confident staff are passing w for Mental Status (BIMS)					
	dated 12/11/13, ind	icated a summary score of 13 5 for cognitive patterns					
	December 2013 un read "Don't appreci (certified nursing as are tot busy to help by R12. Upon revie "Resident/Family G R12's statement re	rievance/Concern Form" for ad, "During resident council					
	and respect, she re was told, I have 30 any grief." R12 did it was in the evenin to Administrator 11/ on the form that she	bu being treated with dignity sponded Not always and said patients today, don't give me not know who it was, only that g and it was a CNA. Reported 7/13. The administrator wrote e interviewed two nursing both denied the allegation.					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
					С		
		00989	B. WING			03/13/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
ARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 [.]				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21990	Continued From pa	ge 71	21990				
		able to produce any estigation or staff education evance.					
	score of 5 out of a	20/13, indicated a summary cossible 15 for cognitive severe impairment.					
	minutes, the quest you are treated with was quotes, "Some you." During an initi on 3/11/14, at 2:09 here abused you R stated, "Verbal abu yelled at for needin at the resident cour disposition for her of continues to have of	ember resident council meeting ion was asked, Do you feel a dignity and respect and R1 of them, evening doesn't help ial observation and interview p.m. when asked has anyone 1 stated Yes and further se has happened, I have been g help and have asked about in ncil." R1 is not aware of the complaint and validated she concerns for abuse and stated, et upset with me and will scold or help."	t				
	documentation, inv	able to produce any estigation or staff education vance expressed from the vember 2013.					
	3/11/14 ,at 1:29 p.n R70 stated, "I have residents and will s you want." R70 said informed and he has that people get yell	al observation and interview or h. when asked about abuse heard the staff bark at ay, I was just in here, what do d that administration has been as told "The powers that be, ed at or scolded here." R70 a feeling that residents are					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
FARIBA	ULT CARE CENTER		LETT AVENUE ILT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21990	and then he feels th R70 mentioned the him have been verts stated, "people are to ask to go to the b yelled at, I have hea R70's BIMS dated 2 score of 14 out of a patterns indicating of The facility was una or concern documa education regarding R59's documents w reviewing a form titl Grievance/Concern "Resident asked for Stated 'everyone all feel like a drug reha out the cards and le Resident showed h this it would hurt. SI problems." The Res by facility staff mem concerns with staff education regarding respectfulness is re When interviewed of verified the staff med did not want to have the situation. R59's BIMS dated 2	he residents are "Shunned!" ladies across the hall from pally abused from the staff and in pain here, people are afraid pathroom because they will get ard it and reported it." 2/18/14, indicated a summary possible 15 for cognitive cognitively intact. able to produce any grivance ntation, investigation or g R70's grievance. were reviewed and upon ed Resident/Family dated 2/18/14, by R59 read, r his pills staff went off on him. ways wants these pain pills. I ab. Then said I should just get et them just take them.' is stomach and said if you had he stated I've had worse sponse /Internal investigation aber read, "Reviewed involved and did staff g verbalizing frustration and esident infraction." on 3/13/14, at 1:15 p.m., R59 ember was disrespectful and e anymore conversation about 2/19/4, indicated a summary possible 15 for cognitive				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FARIBA	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From pa	ge 73	21990			
	The facility was una documentation, inve regarding R59's grid	estigation or staff education				
	council meeting No week in the evening lady came into his r Resident could not happened. The inte read, the writer call to residents legs be moved his legs, but	rievance during a resident vember 2012, and read, "Last g he was in bed and a Chinese oom and twisted his leg. give day or time this ernal investigation in summary ed staff at home, who referred sing tangled in the sheet, the refused to get up, brief ged him in bed by moving his ver.	,			
	score of 12 out of a	25/13, indicated a summary possible 15 for cognitive moderate impairment.				
	The facility was una documentation, inve regarding R16's grid	estigation or staff education				
	problem with [NA-Z to me, she said, 'I s everyday,' It was he thought the incident requested care and The response to the	e concern which read, "Had a], She was rude and abusive houldn't have to do this er tone, terrible attitude." R63 t was at night on Sunday. R63 t the staff member did nothing. e grievance read, "Talked to remember being this way, factual."				
		/12/13, indicated a summary possible 15 for cognitive cognitively intact.				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00989	B. WING			C 13/2014
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
JLT CARE CENTER					
SUMMARY STA		-		CORRECTION	(X5)
		PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIATE	COMPLET DATE
Continued From pa	ige 74	21990			
documentation, inv	estigation or staff education				
"Abuse Prevention read, "Interview the witnesses. Witness (1) witnessed or he close contact with t incident {including of members}; and (3) closely with the acc alleged victim the d written statements the accused, and e policy defines verba written or gestured	Plan" under step 6. Investigate resident, the accused, and all es shall include anyone who: ard the incident; (2) came in he resident the day of the other residents, family employees who worked used employee (s) and/or lay of the incident. Obtain from the resident, if possible, ach witness." The facility al abuse as, "The use of oral, language that willfully includes				
administrator was u documentation from the protection, inve- on abuse related to R12, R1, R70, R59 don't know why the abuse." The admini- were dealt with but documentation to c complaints. The ad resident complaints should have been r The administrator w have been protected verbal abuse and th	nable to produce any n any other source regarding stigation, education or training the specific grievances for , R16 or R63 and stated, "I y weren't reported as verbal istrator thought the grievances could not produce any oincide with the resident ministrator validated the were verbal abuse and eported to the State Agency. ralidated the residents should d pending investigation of the ne abuse prevention plan was				
	OF CORRECTION PROVIDER OR SUPPLIER JLT CARE CENTER SUMMARY STA (EACH DEFICIENCC REGULATORY OR L Continued From pa The facility was una documentation, inv regarding R63's gri A review of the faci "Abuse Prevention read, "Interview the witnesses. Witness (1) witnessed or he close contact with t incident {including of members}; and (3) closely with the acc alleged victim the do written statements the accused, and e policy defines verba written or gestured disparaging and de During an interview administrator was u documentation from the protection, inve on abuse related to R12, R1, R70, R59 don't know why the abuse." The admin were dealt with but documentation to c complaints. The ad resident complaints should have been r The administrator v have been protecter verbal abuse and th	OF CORRECTION IDENTIFICATION NUMBER: 00989 00989 PROVIDER OR SUPPLIER STREET AL JLT CARE CENTER 1738 HU FARIBAU FARIBAU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 The facility was unable to produce any documentation, investigation or staff education regarding R63's grievance. A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." The facility policy defines verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation from any other source regarding the protection, investigation, education or training on abuse related to the specific grievances for R12, R1, R70, R59, R16 or R63 and stated, "I don't know why they weren't reported as verbal	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00989 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATEMENT OF DEFICIENCIES JLT CARE CENTER 1738 HULETT AVENUE FARIBAULT, MN 5502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 74 21990 The facility was unable to produce any documentation, investigation or staff education regarding R63's grievance. 21990 A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident {including other residents, family members}; and (3) employees who worked closely with the accused employee (s) and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness." 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WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY WIST BE PRECEDED BY FULL ID REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDER TAG Continued From page 74 21990 Continued From page 74 21990 The facility was unable to produce any documentation, investigation or staff education regarding R63's grievance. A review of the facility policy dated 3/5/13, titled "Abuse Prevention Plan" under step 6. Investigate read, "Interview the resident, the accused, and all witnesses. Witnesses shall include anyone who: (1) witnessed or heard the incident; (2) came in close contact with the resident the day of the incident (Including other residents, family members}; and (3) employees who worked closely with the accused mployee (s) and/or alleged victim the day of the incident. Obtain written or gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation to coincide with the grievances for R12, R1, R70, R59, R16 or R63 and stated, "I don't know why they weren't reported as verbal abuse." The administrator validated the resident complaints. The administrator validated the resident complaints were verba	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 0030 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1738 HULETT AVENUE NORTH SUMMARY STATEMENT OF DEFICIENCE INCOMENTATION ON LGC DEFIDIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION AUDU DE CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY ON LGC DEFIDIENCY Continued From page 74 100 PREPRX CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY Continued From page 74 21990 21990 CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY Continued From page 74 21990 21990 CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY Continued From page 74 21990 21990 CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY Cose contact with the resident, the accused, and all witnesses. Witnesses shall include anyone who: Cose contact with the resident (2) cane in close contact with the resident (2) and in members); and (3) employees who worked Close contact with the resident. Eve of oral, written a gestured language that willfully includes disparaging and derogatory terms to residents." During an interview on 3/13/14, at 1:30 p.m. the administrator was unable to produce any documentation from any other source regarding on buse related to the specific grievances for R12, R1, R70, R50, R16 or R63 and stated, "1 don't know why they weren't reported as v

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00989	B. WING			C 13/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21990	potential abuse are immediately reporter residents are protect while an investigation Administrator, direct could assure policies implemented and a completed.	ssure that all allegations of thoroughly investigated and to the state agency and that cted from potential retaliation				
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor- prevention plan. Th assessment of the environment, and it factors which may e and a statement of to minimize the risk comply with any rule promulgated by the	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency.				
	agency and person providers, shall dev prevention plan for residing there or rea The plan shall conta assessment of: (1) abuse by other indiv vulnerable adults; (2)	including a home health care al care attendant services elop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
			-			С
		00989	B. WING		03/	13/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ARIBAU	JLT CARE CENTER		LETT AVENUE JLT, MN 5502 ⁻	-		
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 76	22000			
	specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.					
	and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Unc of a vulnerable adu misconduct or phy such information fre authority or through another facility, and	except home health agencies attendant services providers, herable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to hat the vulnerable adult might ected to pose to visitors to the soutside the facility, if der this section, a facility knows ult's history of criminal visical aggression if it receives on a law enforcement in a medical record prepared by other health care provider, or g assessments of the	3			
	by: Based on interview facility failed to imp and procedures to allegations of poter investigate allegation report allegations of facility's administra 8 residents (R1, R1	ent is not met as evidenced and document review the element established policies protect residents who reported ntial abuse, thoroughly ons of abuse and immediately of potential abuse to the tor and state agencies for 6 of 12, R16, R59, R63, R70) in the ed allegations of abuse.				
	Findings include:					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00989	B. WING			C 13/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
			ETT AVENUE			
FARIBA	JLT CARE CENTER		ILT, MN 55021			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
22000	Continued From pa	ige 77	22000			
	allegation of potent to thoroughly invest the resident from po- investigation was po- the allegation to the A review of the facil "Abuse Prevention read, "Interview the witnesses. Witness (1) witnessed or he close contact with to incident {including of members}; and (3) closely with the acco- alleged victim the do- written statements the accused, and e policy defines verba- written or gestured	, R63 and R70 reported an ial abuse and the facility failed tigate the allegation, protect otential abuse while an ending and immediately report e state agency lity policy dated 3/5/13, titled Plan" under step 6. Investigate resident, the accused, and all es shall include anyone who: ard the incident; (2) came in he resident the day of the other residents, family employees who worked cused employee (s) and/or lay of the incident. Obtain from the resident, if possible, ach witness." The facility al abuse as, "The use of oral, language that willfully includes rogatory terms to residents."				
	the administrator, s further documentat regarding the prote or training on abuse grievance for R1, R and stated, "I don't reported as verbal a thought the grievan produce any docum resident complaints the resident complaints the resident complaints the resident complaints	r on 3/13/14, at 1:30 p.m. with he was unable to produce any ion from any other source ction, investigation, education e related to the specific f12, R16, R59, R63 or R70 know why they weren't abuse." The administrator ices were dealt with but cannot nentation to coincide with the s. The administrator validated aints were verbal abuse and eported to the State Agency. validated the residents should id pending investigation of the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00989	B. WING		C 03/13/201	4
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ARIBAL	ILT CARE CENTER		LETT AVENUE JLT, MN 5502			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA	(5) PLE1 ATE
22000	Continued From pa	age 78	22000			
	not implemented for	or those residents.				
	The facility could a procedures for abuit implemented, enfor potential abuse are	THOD OF CORRECTION: ssure established policies and ise prevention plan are rced and that allegations of a thoroughly investigated. R CORRECTION: Twenty One				
nanata D	epartment of Health					