DEPARTMENT OF HEALTH AN	ND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 53NP
	PART I	- TO BE COMP	LETED BY T	'HE STA'	TE SURVEY AGENCY	Facility ID: 00461
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245512		3. NAME AND AI (L3) FIRST CAR				4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 900 HILLIG		ARD SOU		3. Termination 4. CHOW
(L2) <b>381347904</b>		(L5) FOSSTON, 1	MN		(L6) <b>56542</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other
<ol> <li>EFFECTIVE DATE CHANGE OF OWNER (L9)</li> </ol>	RSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 11/22/201	<b>3</b> (L34)	02 SNF/NF/Dual	05 HHA 06 PRTF	10 NF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	10 I G	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	_(210)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:		·
From (a):		A. In Complia			And/Or Approved Waivers Of Th	ne Following Requirements:
To (b):			Requirements ice Based On:		2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	<b>50</b> (L18)		Acceptable POC		<ul> <li>3. 24 Hour RN</li> <li>4. 7-Day RN (Rural SNF</li> <li>5. Life Safety Code</li> </ul>	<ul> <li>7. Medical Director</li> <li>8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>50</b> (L17)		mpliance with Prog ents and/or Applied		* Code: <b>A</b>	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
<u>Lyla Burkman, Unit Sup</u>	ervisor		02/04/2014	(L19)	<u>Shellae Dietrich, P</u>	rogram Specialist 02/06/2014
PAR	T II - TO BI	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH	CIVIL	21. 1. Statement of Finar	
<b>X</b> 1. Facility is Eligible to Partici	nate	RI	GHTS ACT:		<ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	pute					
	(L21)					
22. ORIGINAL DATE 23	3. LTC AGREEM	IENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	<u>VOLUNTARY</u> <u>00</u>	INVOLUNTARY
01/01/1988					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	
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-Provider Status Change
(L27)	B. Rescind Sus	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE		
	(L32)	11/27/2013		(L33)	DETERMINATION APPR	OVAL

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

#### CCN 24-5512

On September 6, 2013 we completed an OTC Survey at this facility. The most serious deficiency was at a S/S level of F.

Day 70 for this enforcement cycle was November 15, 2013. Compliance with the health and life safety code deficiencies had not yet been verified. The most serious deficiency is at a S/S level of F. As a result of our findings and the 70th day, we recommended the following remedy to the CMS RO for imposition and CMS RO concurred:

Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective December 6, 2013

If DOPNA goes into effect, the facility would be subject to loss of NATCEP for two years beginning December 5, 2013.

On November 22, 2013, health completed a PCR and on November 21, 2013, life safety completed a PCR and all deficiencies were corrected. As a result of the revisit findings, we recommended the following to the CMS RO for imposition and CMS concurred:

Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective December 6, 2013, be rescinded.

Since DOPNA didn't go into effect. The facility would not be subject to a loss of NATCEP.

See attached CMS-2567B for the revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN 245512

February 6, 2014

Mr. Kevin Dish, Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

Dear Mr. Dish:

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 November 8, 2013 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: (651) 201-4106 Fax #: (651) 215-9697 cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7011 2000 0002 5143 7272

November 17, 2013

Mr Kevin Dish, Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

RE: Project Number S5512023, F5512022

Dear Mr. Dish:

On September 27, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 6, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 8, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on September 6, 2013.

The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

 Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 6, 2013. (42 CFR 488.417 (b)) First Care Living Center November 17, 2013 Page 2

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 6, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 6, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, First Care Living Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 6, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the September 5, 2013 revisit is enclosed.

#### APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

First Care Living Center November 17, 2013 Page 3

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

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 March 6, 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0541 First Care Living Center November 17, 2013 Page 4

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5512r70dayLtr.rtf

#### **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 245512	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/22/2013
Name	e of Facility		Street Address, City, State, Zip Code	-
FI	RST CARE LIVING CENTER		900 HILLIGOSS BOULEVARD S FOSSTON, MN 56542	OUTHEAST

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 Reg. # LSC	483.10(e), 483		Correction Completed 11/08/2013	ID Prefix Reg. # LSC	483.15(a)		Correction Completed 11/08/2013		0	483.20(d), 483		Correction Completed 11/08/2013
ID Prefix			Correction Completed 11/08/2013	ID Prefix	F0282 483.20(k)(3)(ii)		Correction Completed 11/08/2013		ID Prefix Reg. #			Correction Completed 11/08/2013
ID Prefix Reg. # LSC	483.25(a)(3)		Correction Completed 11/08/2013	ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 11/08/2013		ID Prefix Reg. #			Correction Completed 11/08/2013
ID Prefix Reg. # LSC	483.25(h)		Correction Completed 11/08/2013	ID Prefix Reg. # LSC	483 20/2)		Correction Completed 11/08/2013			F0411 483.55(a)		Correction Completed 11/08/2013
ID Prefix Reg. # LSC	483.65		Correction Completed 11/08/2013	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 11/08/2013					
Reviewed I State Agen Reviewed I CMS RO	cy	Reviewed MM/2 Reviewed	LB	Date: 02/04/201 Date:	Signature 3 Signature	2	8035				Date: 11 Date:	/22/2013
Followup1	to Survey Com 9/6/20	-	1:		Check for any Uncorrected					Summary of the Facility?	YES	NO

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 245512	(Y2) Multiple Construction A. Building B. Wing 01 - NURS		SING HOME	(Y3) Date of Revisit 11/21/2013	
Name	of Facility			Street Address, City, State, Zip Code		
FIRST CARE LIVING CENTER				900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		

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) E	Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		09/20/2013	ID Prefix		09/07/2013	ID Prefix			_09/20/2013
•	NFPA 101	-	-	NFPA 101		-	NFPA 101		_
LSC	K0011		LSC	K0025		LSC	K0056		-
					<b>o</b> "				<b>a</b> "
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #		-	Reg. #		-				-
LSC		-				LSC			_
						<u> </u>			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-			-				-
Reg. #		-	Reg. #			Reg. #			_
LSC		<u>.</u>	LSC						
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-	ID Prefix			ID Prefix			_
Reg. #			Reg. #			Reg. #			
LSC		-	LSC			LSC			-
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #						-
•		-				LSC			-
Reviewed By		-	Date:	Signature of Surve	yor:	1		Date:	
State Agency	, MM/F	PS	02/04/20	14	030	06		11/2	1/2014
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to	Survey Completed on:			-		eficiencies. Was	•	+	
	9/5/2013			Uncorrecte	d Deficiencies	(CMS-2567) Sent	to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

February 4, 2014

Mr. Kevin Dish, Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

RE: Project Number S5512023 and F5512022

Dear Mr. Dish:

On November 17, 2013, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 6, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 22, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 6, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on September 6, 2013, and lack of verification of substantial compliance with the health and Life Safety Code (LSC) deficiencies at the time of our November 17, 2013 notice. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 22, 2013, the Minnesota Department of Health completed a completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 21, 2013, the Minnesota Department of Public Saety 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 September 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 8, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 6, 2013, as of November 8, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 22, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

First Care Living Center February 4, 2014 Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 6, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 6, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 6, 2013, is to be rescinded.

In our letter of November 22, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 6, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 8, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

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

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

Sincerely,

#### Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5512r270dayAllCorrltr.rtf

DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL FE SURVEY AGENCY	ID: 53NP Facility ID: 00461
1. MEDICARE/MEDICAID PROVID           (L1)         245512           2.STATE VENDOR OR MEDICAID           (L2)         381347904	DER NO.	3. NAME AND ADE (L3) FIRST CARE (L4) 900 HILLIGC (L5) FOSSTON, M	DRESS OF FACIL LIVING CEN DSS BOULEVA	JTY TER		4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUP 01 Hospital		RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 09/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	6/2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	07 X-Ray	10 NF 11 ICF/IID 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>
<ul> <li>11LTC PERIOD OF CERTIFICATIO From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	<b>50</b> (L18)	10.THE FACILITY I A. In Complianc Program Req Compliance 1. Acc X B. Not in Comp	ee With quirements Based On: ceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
13. Iotai Certified Beds	<b>50</b> (L17)		its and/or Applied		* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REN See Attached Remarks	IARKS (IF APPLICA	BLE SHOW LTC CAN	ICELLATION DA	ATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Jane Anadal, HFE- Nur	sing Evaluato	rll 10/	/28/2013	(L19)	Kate JohnsTon, Enforc	cement Specialist 11/27/2013 (L20)
PA	RT II - TO BE	COMPLETED BY	Y HCFA REG	JONAI	<b>COFFICE OR SINGLE S</b>	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBI</li> <li><u>X</u></li> <li>1. Facility is Eligible to</li> <li><u>2</u>. Facility is not Eligible</li> </ol>	Participate		LIANCE WITH C 'S ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24.	LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 01/01/1988	BEGINNINC		ENDING DATE		VOLUNTARY     00       01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change
(L27)	-	n of Admissions: Ispension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

#### C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

#### CCN 24-5512

At the time of the standard survey completed September 6, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 3108

September 27, 2013

Mr. Kevin Gish, Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

RE: Project Number S5512023

Dear Mr. Gish:

On September 6, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

<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.

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

## DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, Minnesota 56601

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

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 16, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 16, 2013 the following remedy will be imposed:

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

#### PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

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substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 6, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

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Services that your provider agreement be terminated by March 6, 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

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

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

Telephone: (651) 201-7205 Fax: (651) 215-0541 First Care Living Center September 27, 2013 Page 6

Feel free to contact me if you have questions.

Sincerely,

Are Klegepe

Anne Kleppe, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (612) 201-4124 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

ND PLAN C	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512 AME OF PROVIDER OR SUPPLIER IRST CARE LIVING CENTER		(X2) MUL A. BUILD B. WING	ING 51 90	CONSTRUCTION CONSTRUCTION CT 1 5 2013 TREET ADDRESS, CITY, STATE, ZIP CODE DO HILLIGOSS BOULEVARD SOUTHEAST			
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	medical treatment, w communications, per meetings of family ar does not require the room for each reside Except as provided in section, the resident release of personal a individual outside the The resident's right to and clinical records of resident is transferred	rsonal care, visits, and nd resident groups, but this facility to provide a private nt. n paragraph (e)(3) of this may approve or refuse the and clinical records to any			<ul> <li>name.</li> <li>B. Education provided to all fact staff regarding Hipaa and Protecting Confidentiality by Mandatory License Staff Meeting October 9 and Mandator Staff Meeting October 10, 2013.</li> <li>C. Education provided in an Informational package to staff not attending to be completed prior to the next scheduled shift and to all new employee orientation.</li> <li>D. Compliance reported to QAP meetings quarterly.</li> </ul>	d iry All ir	All Compl are 11/8/1	

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

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

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	contained in the res the form or storage release is required	ep confidential all information sident's records, regardless of methods, except when by transfer to another n; law; third party payment dent.				
	by: Based on observative review, the facility finformation was not 23 residents (R50, R68, R59, R37, R36 R55, R11, R42, R3, the South dining roo R40, R41, R58, R5, R57, R44, R31, R10 R70, R45, R23, R55	REQUIREMENT is not met as evidenced ed on observation, interview and document w, the facility failed to ensure private dietary nation was not accessible to the public for sidents (R50, R19, R13, R29, R26, R33, R59, R37, R38, R56, R34, R66, R15, R27, R11, R42, R3, R1, R51, R43, R20, R67) in outh dining room and for 24 residents (R24, R41, R58, R5, R21, R69, R65, R46, R6, R44, R31, R16, R48, R36, R39, R8, R2, R45, R23, R52) in the North dining room.			×	
	done in the the Sou were observed seat dietary cards on a s resident. The dietar first and last name a	b.m. a dining observation was th dining room. Residents' red at the tables, with yellow tand placed in front of each y card included the resident's and their diet according to the his information was visible to dining room.				
	R50-regular diet, tex liquids at breakfast,	om dietary cards read: kture as tolerated, nectar thick thin liquids rest of day.				
	R19, R13, R33, R15 and R67 all had reg	5, R43, R51, R3, R42, R11 ular diets.				

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	R26-mechanical so have nectar liquids a meal. R68 and R59 both I R37 and R27 both I regular liquids. R38-regular diet, sr R56-regular diet, sr R56-regular liquids. R66-regular diet, no R55-mechanical so R1-pureed diet with R20-low salt diet. On 9/4/13, at 8:57 a done in the the Sou yellow dietary cards resident information placed in front of ea On 9/5/13, at 7:57 a done in the the Sou yellow dietary cards placed in front of ea On 9/5/13, at 12:13 manager (NSM), ve included the resider stated there was a I cupboard that identi She stated staff con cupboard for the info	dium, low fat diet. ft food, ground meat and b added salt. ft diet with pureed meat. honey thick liquids. a.m. a dining observation was th dining room. The same which displayed personal a were observed on a stand ach resident. a.m. a dining observation was th dining room. There same were observed on a stand ach resident. p.m. the nutrition services rified the dietary cards nts' diet order. The NSM ist in the dining room fied the residents' diet order. Jud just look inside the ormation. The NSM stated king with registered nurse				
	manager (NSM), ve included the resider stated there was a l cupboard that identi She stated staff con cupboard for the info she had been speak (RN)-D recently abo questioned whether NSM also verified th	rified the dietary cards hts' diet order. The NSM ist in the dining room fied the residents' diet order. Juld just look inside the formation. The NSM stated king with registered nurse ut the dietary cards, and it was a privacy issue. The he residents in the North so using the dietary cards		107-00/61 (6 continue		

Facility ID: 00461

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/27/2013 APPROVED . 0938-0391
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F 164 F 241 SS=E	R69, R6, R57, R44, R16, R45, and R52 R24-renal diet, low restriction. R40-ground meat te R41-regular texture nectar thick liquids. R58-mechanical so R5-regular diet with R21-mechanical so R65-low fat, low soo R46-low potassium R31-pureed lactose liquids. R39-regular 3-4 car sweets diet. R8-pureed diet with R23-regular low soo The PRIVACY NOT dated 4/03, indicate copy of the Privacy their protected healt The policy further in other personnel can information. 483.15(a) DIGNITY INDIVIDUALITY The facility must pro-	I diet order listed. om dietary cards read: . R36, R48, R2, R70, R67, all had regular diets potassium, 1400 ml fluid exture, lactose free diet. with no mixed textures, ft foods. small portions. ft diet with ground meat. dium diet. diet. free diet with honey thick bohydrates, no concentrated regular liquids. lium diet with ground meat. ICE POLICY & PROCEDURE d residents would receive a Notice that would explain how th information would be used. dicated employees, staff and access the resident's AND RESPECT OF	F 1	41	It is the policy of FCLC to promote dig and respect of residents. A. Charge nurse to ensure that residents R13, R29, R15 receive timel breakfast daily x 2 weeks then random thereafter.	у	

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STATEMEN	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
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F 241	This REQUIREMEI by: Based on observa failed to provide tim promoted dignity fo R15) in the sample Findings include: R13 did not receive manner on the mor R13's diagnoses in shortness of breath Set (MDS) dated 8/ and oriented, requir activities of daily liv eating. The plan of care (P R13 tolerated a reg with eating after the On 9/4/13, at 9:00 a room, seated in a w (NA)-C stated R13 stated she was not breakfast or not. N/ into assisting him w cares to R13's room - At 9:25 a.m. NA-C opened the curtain R13 stated "I thoug me." NA-C assured R13 she would assi what he wanted to a	NT is not met as evidenced tion and interview, the facility hely meals in a manner which r 3 of 3 residents (R13, R29, who did not receive breakfast. e breakfast in a timely dignified ning of 9/4/13. cluded muscle weakness and b. The quarterly Minimum Data 20/13, indicated R13 was alert red extensive assistance with ing and supervision with OC) dated 8/28/13, indicated ular diet and was independent e meal was set up by staff. a.m. R13 was observed in his theelchair. Nursing assistant was waiting for his bath. She sure if R13 had received A-C reported she would look with breakfast after providing mate (R29). completed cares on R29 and between the two residents. ht you had forgotten about d the resident and informed ist with breakfast and asked	F 241	CONTINUED - F241-E B. Audits to ensure all resident offered timely meals/snacks and recor- resident records by Dietary Manager x 4 weeks and randomly thereafter. C. Meals/snacks will be offered resident's room by the end of design- mealtime if unable to get to dining an assist by nursing staff per individual I D. All staff educated for compli- with meal assistance by Mandatory Licensed Staff meeting October 9 an Mandatory All Staff Meeting October 2013. E. Education provided in an informational package to staff not atter to be completed prior to their next scheduled shift and to all new employ orientation. F. Compliance reported to QAI meetings quarterly.	brded in weekly d in ated ea, POC. ance d 10, ending yee	

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		AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM /IB NO.	09/27/2013 APPROVED 0938-0391
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F 241	would be a long tim him she would bring then wheeled R13's room. - At 9:40 a.m. NA-C dining room. She h coffee as she had p - At 9:45 a.m. R13 towards the tub roo that he had not rece continued to wheel - At 9:47 a.m. NA-C delivered toast and She was informed F R13 will remind her bath. - At 10:10 a.m. R13 from the tub room. - At 10:12 a.m. NA- breakfast and he wis stated she did not k received breakfast. - At 10:20 a.m. R13 breakfast at the tab became tearful whe why he did not alwa asked if he was hur was too late to eat i lunch was served. offered to bring him returned with anythi late and he was "ma On 9/4/13, at 11:30 the dining room anc - At 12:06 p.m. R13	<ul> <li>e before lunch and assured g him toast and coffee. NA-C s roommate (R29) out of the</li> <li>c fed R29 breakfast in the lad not brought R13 toast or promised him.</li> <li>was wheeled out of his room</li> <li>m. R13 explained to NA-D</li> <li>bive breakfast. NA-D</li> <li>R13 towards the tub room.</li> <li>c confirmed she had not</li> <li>coffee to R13 as promised.</li> <li>R13 was in the tub and stated</li> <li>of the breakfast after his</li> <li>was returned to his room</li> <li>D reported R13 had refused</li> <li>build wait until lunch. She</li> <li>now why R13 had not</li> <li>stated he usually ate</li> <li>le when he was at home. He</li> <li>m he stated he did not know</li> <li>ys get breakfast. When</li> <li>ngry, R13 stated yes, but it</li> <li>t as it was only an hour until</li> <li>He confirmed the staff had</li> <li>breakfast but they had not</li> <li>ng. R13 stated it was just too</li> <li>a.m. R13 wheeled himself to</li> <li>I received lunch.</li> <li>stated he was fully satisfied</li> <li>tated, "I don't know why I</li> </ul>	F 2	41			

Facility ID: 00461

If continuation sheet Page 6 of 62.

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F 241	stated she had bee received breakfast usually ate breakfast stated that was not stated R13 had not manner regarding h R29 did not receive 9/6/13. R29's diagnoses ind behavioral disturbar anxiety. The quarter indicated R29 had s and required extens activities of daily livi R29's POC dated 7/ with meals as need On 9/6/13, at 8:00 a resting in bed with h - At 9:00 a.m. R29 v - At 10:15 a.m. R29 bed. - At 10:30 a.m. R29 received breakfast. - At 11:20 a.m. R29 room during for lund R15 did not receive 9/6/13. R15's diagnoses ind	<ul> <li>p.m. registered nurse (RN)-A n informed R13 had not this morning. She stated R13 st in the dining room and R13's normal routine. She been treated in dignified his breakfast meal.</li> <li>breakfast on the morning of</li> <li>cluded dementia with noces, paranoid states and erly MDS dated 5/25/13, severe cognitive impairment sive assistance with all ng including eating.</li> <li>/17/13, directed staff to assist ed.</li> <li>h</li></ul>	F 241			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA CO	TE SURVEY MPLETED	
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F 241	Continued From pa	age 7	F 24	1			
	with activities of da	uired extensive assistance ily living. The MDS also able to feed himself.					
	feed himself after th	5/22/13, indicated R15 could he meal was set up by staff. staff to set up his meal and					
	breakfast meal in th	a.m. R15 was served his ne dining room and was 0% of the meal independently.					
	resting in bed. At 9	a.m. R15 was awake and :00 a.m. R15 stated he was .m. R15 was observed to have I.					
	and R29 had not re stated the facility wa they were having di	a.m. NA-A confirmed R15 ceived their breakfast. NA-A as short two NA's therefore, fficulty keeping up with the nts. NA-A stated he would with cares.					
	stated she delivered dining rooms at 7:3 9:00 a.m. She state residents received t	a.m. dietary assistant (DA)-A d the breakfast cart to the 0 a.m. and picked them up at d she was not sure when the heir breakfast meals. She not been asked to leave a R15 or R29.					
	manager (CDM) sta serving the resident residents were to be breakfast between 5	a.m. the certified dietary ted the facility was currently is on a five meal plan. The offered a continental 7:30 a.m. to 9:00 a.m. lunch 11:00 a.m. snacks at 2:00					

If continuation sheet Page 8 of 62

STATEMENT OF DEFICIENCIES       (M1 PROVIDERSUPPLIER)       (M2 PLAN OF CORRECTON)       (M2 PLAN OF CORRECTON)         AND PLAN OF CORRECTON       24512       B. WING       (M2 PLAN OF CORRECTON)       (M2 PLAN OF CORRECTON)         NAME OF PROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES       SUMMARY STATEMENT OF DEFICIENCIES       SUMMARY STATEMENT OF DEFICIENCIES       (M2 PLAN OF CORRECTON)       (M2 PLAN OF CORRECTON)         PAREINX       SUMMARY STATEMENT OF DEFICIENCIES       (M2 PLAN OF CORRECTON)       (M2 PLAN OF CORRECTON)       (M2 PLAN OF CORRECTON)         PAREINX       REQULATORY OR LSC IDENTIFYING ANFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES       (M2 PLAN OF CORRECTON)       (M2 PLAN OF CORRECTON)         PAREINX       REQULATORY OR LSC IDENTIFYING ANFORMATION)       PREINX       PROVIDER PLAN OF CORRECTOR ATONS SINCULO BE       (M2 PLAN OF CORRECTON)         F 241       Continued From page 8       F       F       F241         F meand plan the residents worked with the five masked by 10.30 cm. Bit stated with the residents of the callity, she asked the normal routines which included what time they had each breaktast prior to Affingston. However, she confirmed she did not document the finding room or their rooms. The CDM was not ware R15 and R29 were observed to be stilling in the dining room or their rooms. The CDM was not ware R15 and R29 were served lunch.       F 279         Had not received b meaktast meals. At 11:20 a.m. R15 and R29 were observed to be stilling in the dining r			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/27/2013 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY, STATE. ZP CODE       FIRST CARE LIVING CENTER     STREET ADDRESS. CITY, STATE. ZP CODE       (4) D PHEFIX TAG     SUMMARY STATEMENT OF DEPICIENCES. (EACH OPERCIPCY MSI'S EF PROVIDERED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     D PROVIDERS GTA.NDF CONRECTION (EACH OPERCIPCY MSI'S EF PROVIDENCE ATOTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     000000000000000000000000000000000000	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
IMAME OF PROVIDER ON SUPPLIER     STREET ADDRESS, CTV, STATE, JP CODE       PIRST CARE LIVING CENTER     SUMAARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY ON LSC DENTIFYING INFORMATION)     D PRETX TAG     PROVIDER STALE, JP CODE SOUTE AATON STORMETTON (EACH OPERCIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     CM0 (MALLOOS SATEFERENCED ACTION MALLOOS SATEFERENCED TO THE APPROPRIATE DEFICIENCY     CM0 (MALLOOS SATEFERENCED TO THE APPROPRIAT			245512	B. WING	·····	09/	06/2013
Prior Darke Living CENTER       POSSTON, MN 56542         (X4) D       SUMMARY STATEMENT OF DEFICIENCIES       PROVIDERS ALLA OF CORRECTION ECONFICTION CONFIDENCE       Configure CENTER ALLA OF CORRECTION ECONFICTION ECONFICTION ECONFICTION CONFIDENCE       Configure CENTER ALLA OF CORRECTION ECONFICTION ECONFIDENCE       Configure CENTER ALLA OF CORRECTION ECONFIDENCE       Configure CENTER ALLA OF CONFIDENCE       Configure CENTER ALLA OF CENTER ALLA OF	NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MURT BE PRECEDED BY FULL RESULTION OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE       construct to the construction of the cons	FIRST C	ARE LIVING CENTER					
<ul> <li>p.m. supper at 4:30 p.m. and a bedtime snack was to be served at 6:00 p.m. She stated with the five meal plan the residents were allowed to wake up on their own and they could eat when they were ready. She stated by 10:30 a.m. all of the residents in the facility should have been offered some sort of breakfast. She explained, when the residents were allowed in the facility, should have been offered some sort of breakfast. She explained, when the residents were admitted to the facility, she asked them what they like to eat and what was their normal routines which included what time they had eaten breakfast prior to admission. However, she confirmed she did not document the findings in the residents clinical records. The CDM explained if the residents chose to stay in bed after 9:30 a.m. the staff should be offering them something to eat either in the dining room or their rooms. The CDM was not aware R15 and R29 had not received breakfast meals. The CDM reviewed the bedtime snack documentation and reported R15 and R29 had received bettime snacks on the evening of 9/5/13.</li> <li>On 9/6/13, at 11:00 a.m. R15 and R29 were observed to be sitting in the dining room. R15 stated he had not received inscharts meal. At 11:20 a.m. R15 and R29 were served lunch.</li> <li>The LTC (long term care) Resident Dietary Program and Dining Experience policy dated 3/6/07, indicated the residents at the facility were to receive 3 meals and 2 snacks daily.</li> <li>F 279</li> <li>K 483.20(d), 483.20(k)(1) DEVELOP</li> <li>SS=E</li> <li>COMPREHENSIVE CARE PLANS</li> <li>A facility must use the results of the assessment to develop, review and revise the residents' comprehensive plan of care.</li> <li>F 279</li> </ul>	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
	F 279 SS=E	p.m. supper at 4:30 was to be served at five meal plan the re up on their own and were ready. She sta residents' in the faci some sort of breakfi residents were adm them what they like normal routines whithad eaten breakfast she confirmed she co in the residents clinitexplained if the residents after 9:30 a.m. the s something to eat eith rooms. The CDM wathad not received breat reviewed the bedtim reported R15 and R2 snacks on the evenite On 9/6/13, at 11:00 at observed to be sittin stated he had not received breat to receive 3 meals at 483.20(d), 483.20(k) COMPREHENSIVE A facility must use that to develop, review ar	p.m. and a bedtime snack 6:00 p.m. She stated with the esidents were allowed to wake they could eat when they they by 10:30 a.m. all of the lity should have been offered ast. She explained, when the itted to the facility, she asked to eat and what was their ch included what time they prior to admission. However, lid not document the findings cal records. The CDM dents chose to stay in bed taff should be offering them her in the dining room or their as not aware R15 and R29 eakfast meals. The CDM e snack documentation and 29 had received bedtime ng of 9/5/13. a.m. R15 and R29 were g in the dining room. R15 ceived his breakfast meal. At R29 were served lunch. care) Resident Dietary Experience policy dated e residents at the facility were nd 2 snacks daily. (1) DEVELOP CARE PLANS e results of the assessment ind revise the resident's		<ul> <li>9</li> <li>It is the policy of FCLC to develop, rev and revise the residents' comprehensi plan of care</li> <li>A. Comprehensive assessment reviewed and care plan revised as</li> </ul>	ve	

Facility ID: 00461

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

PRINTED: 09/27/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NC	<u>). 0938-0391</u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		TE SURVEY MPLETED
		245512	B. WING	ì		09	/06/2013
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ARE LIVING CENTER				900 HILLIGOSS BOULEVARD SOUTHEAST		
	And LIVING CENTER		-		FOSSTON, MN 56542		
(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
	plan for each reside objectives and time medical, nursing, al needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any so be required under § due to the resident's §483.10, including t under §483.10(b)(4) This REQUIREMEN by: Based on observati review, the facility fa comprehensive plar resident (R24) to inc dialysis access port. to develop a POC to interventions for rep (R15, R38) identified Findings include: R24 lacked a compr monitoring of a dialy R24 was diagnosed and end stage renal Minimum Data Set ( R24 had no cognitive	<ul> <li>velop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive</li> <li>describe the services that are tain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided a exercise of rights under the right to refuse treatment of care (POC) for 1 of 1 clude the monitoring of a ln addition, the facility failed include identified ositioning for 2 of 4 residents d at risk for pressure ulcers.</li> <li>ehensive POC to address the sis access port.</li> <li>with diabetes, heart disease failure. The quarterly MDS) dated 6/4/13, indicated</li> </ul>	F2	279	CONTINUED-F279-E B. Comprehensive assessment reviewed & plan of care revised as appropriate to include monitoring of d access port for resident R24. C. Treatment Assessment Reco (TAR) updated to have staff nurses si to monitor the dialysis access port da TAR instruct staff nurses not to take b pressure on the same arm as the dial access port. TAR instruct staff nurses monitor for bleeding and interventions case the access site starts to bleed. D. Comprehensive plan of care reviewed & care plans revised as appropriate to include interventions for repositioning for residents R15, R38 v were identified for risk of pressure ulc E. RNCC or her designee will p repositioning (sitting and lying) audits weekly x 4 weeks for residents R15 at R38 and randomly thereafter. F. RNCC will update care plans quarterly and with any significant char daily as they occur. G. Random audits for all other residents at risk for pressure ulcers w completed weekly for 4 weeks then or random basis by RNCC's or her desig ensure ongoing compliance with repositioning. H. DON or designee will audit 4 resident records monthly for complian- with care plan updates.	ialysis ord gn off ily. lood ysis to i in r vho ers. erform nd nges ill be n a nee to	

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

Event ID:53NP11

Facility ID: 00461

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

CENTERS	<u>5 FOR MEDICARE</u>	& MEDICAID SERVICES			C	MB NO	. 0938-0391
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245512	B. WING	I		09	/06/2013
NAME OF PRO	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	00 HILLIGOSS BOULEVARD SOUTHEAST		
	RE LIVING CENTER	1944-1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1		F	FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
R direre rea in a P co and politot fam with fam pl TH de with fai a sinf the fai a sinf the fai the fai a sinf the fai a fai a si a fai a fai a fai fai a si fai a si fai fai fai fai fai fai fai fai fai fa	ialysis three times enal disease. The f enal diet and was o nd directed staff to ntake weekly, provio nd snacks and also OC also indicated ould be given via th pproved by nephro ever occur in an ex- ort. The POC direct lood pressure prior o direct staff not to a same arm the di alled to identify who nonitoring the site o as to be monitored lace if the access s he facility's North n ome Plan of Care f eveloped and supp hich directed staff to ressure on the extro cress. This plan of rotection of a patier ealth and well-being rected facility staff e extremity access eling for a pulsation bruit via stethoscop sessing for redness fection. The plan of cessing and bandago ours following dialys ad if staff were unal	ge 10 (12/13, indicated R24 had a week due to end stage POC indicated R24 received a in 1000 - 1500 fluid restriction monitor weight and oral de sufficient fluids thru meals to to provide education. The no medications or solutions he dialysis access port unless logist and lab draws should thremity containing a dialysis ted staff to monitor R24's to dialysis, however, it failed take the blood pressure on alysis site was. The POC also was responsible for r how often the access site or what interventions were in ite started to bleed. urse's station had a Nursing or Hemodialysis Patients lied by R24's dialysis provider to never to take blood emity that contains a dialysis care also noted the nts access was critical to their g on hemodialysis and to perform a daily check of . This daily check included n in the access, listening for be in the access and s, warmth or signs of f care indicated the access pes may be removed with 6-8 sis and if there was bleeding be to stop the bleeding, fy the dialysis unit or	F 2	279	CONTINUED F279-E I. All staff educated for care p compliance by Mandatory Licensed s meeting October 9 and Mandatory Al Meeting October 10, 2013. J. Education provided in an informational package to staff not atte to be completed prior to their next scheduled shift and to all new employ orientation. K. Compliance reported to QAI meetings quarterly.	staff I Staff ending /ee	

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

Facility ID: 00461

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

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245512	B. WING	·		09/	/06/2013
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	nephrologist for furt On 9/6/13, 8:20 a.m on the bed removin access site. R24 sta bleeding or signs of also stated the nurs the access site and about it. On 9/6/13, at 7:03 a stated R24's access a dressing when sh the nurses did not d stated when the site something in the ele administration recor now they don't have blood pressures we of the access site at interventions related directing staff which on. On 9/6/13, at 10:15 nurse (LPN) and wa the POC but stated stated there used to check the access si was discontinued or The dialysis policy th Nursing Home Plan Patients developed I R15's POC dated 8 risk for the developed I	her instructions. her instructions. her instructions. her instructions. her instructions of the ated she would report any infections to the nurse. R24 es had not routinely checked sometimes would ask her ask her ask her registered nurse (RN)-B is site was always covered with e returned from dialysis and o anything to the site. RN-B was new there was be was new there was be was new there was be to do anything. RN-B stated re not to be taken in the arm nd verified the POC lacked it to monitoring the site or arm to take blood pressure a.m. the licensed practical rd clerk verified it was not on it could be added. The LPN be an order in the e-mar to te daily but for some reason it	F2	279			

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

Event ID:53NP11

Facility ID: 00461

If continuation sheet Page 12 of 62

TATEMEN	T OF DEFICIENCIES DF CORRECTION	A MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
		245512	B. WING			09/06/2013	
	PROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE 0 HILLIGOSS BOULEVARD SOUTHEAST DSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 279	frequency to which On 9/5/13, a 7:05 a main lobby, seated body mechanical li R15 was assisted breakfast. At 8:24 dining room and do lobby. While in the asleep while in the assistance. At no t able to reposition h 10:33 a.m. nursing staff members had around 6:30 a.m. S been repositioned NA-A then assisted mechanical lift. R11 be equipped with a cushion. R15's skir intact free of press At 10:40 a.m. NA-r received assistance 6:30 am. and 10:33 minutes. On 9/5/14, at 12:35 stated R15 was to repositioning every should have been r regarding the repos R38's diagnoses in ulcers (PU), arteria vascular disease (F	rect the staff as to the R15 was to be repositioned. a.m. R15 was observed in the in a wheelchair with a full ft sling under him. At 7:50 a.m. to the dining room for a.m. R15 wheeled out of the own the hallway to the main lobby R15 was observed to fall wheelchair without receiving ime was R15 observed to be simself in the wheelchair. At assistant (NA)-C stated other assisted R15 out of bed She confirmed R15 had not since that time. NA-C and I R15 to bed via a full body 5's wheelchair was observed to pressure redistribution a was observed to be pink and ure ulcers. C confirmed R15 had not e with repositioning between 8 p.m. a total of 4 hours and 3 f p.m. registered nurse (RN)-A receive assistance with two hours and stated the POC evised to direct the staff	F 2	79			

		(X2) MULTIF		FORM APPROVE MB NO. 0938-039 (X3) DATE SURVEY
FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	245512	B. WING		09/06/2013
ROVIDER OR SUPPLIER		E E		
ARE LIVING CENTER	1			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
Continued From pa	ae 13	F 279		
and required two st	aff extensive assistance for			
was at risk for pres- to assist with repos (pressure relief) even however, the POC	sure ulcers and directed staff itioning and offloading ery hour during awake hours, lacked indication of the			
her back at 7:00 a.r turned in bed every turned to her left sic	n. and verified R38 was to be 2 hours. At this time, R38 was le to receive cares. (3 hours	3		
PU's. RN-A stated F every 2 hours while repositioning sched	R38 was to be repositioned in bed. RN-A verified the ule for R38 while in bed was			
directed staff to dev plan for each reside 483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or othe	elop a comprehensive care ent. D(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be	F 280	a right to participate in care planning.	
	ARE LIVING CENTER SUMMARY ST/ (EACH DEFICIENCIES REGULATORY OR L Continued From pa and required two st transfers and bed r R38's current POC was at risk for pres to assist with repos (pressure relief) ev/ however, the POC frequency R38 was while in bed. On 9/5/13, R38 was on her back from 7 At 10:15 a.m. NA-C her back at 7:00 a.r turned in bed every turned to her left sid and 15 min without At 1:02 p.m. RN-A PU's. RN-A stated F every 2 hours while repositioning sched not addressed on th The Care Planning directed staff to dev plan for each reside 483.20(d)(3), 483.11 PARTICIPATE PLAI	AS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES FORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245512         PROVIDER OR SUPPLIER         ARE LIVING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 13 and required two staff extensive assistance for transfers and bed mobility.         R38's current POC dated 8/28/13, indicated R38 was at risk for pressure ulcers and directed staff to assist with repositioning and offloading (pressure relief) every hour during awake hours, however, the POC lacked indication of the frequency R38 was to be turned and repositioned while in bed.         On 9/5/13, R38 was observed continuously in bed on her back from 7:05 a.m. until 10:15 a.m.         At 10:15 a.m. NA-C stated R38 was placed on her back at 7:00 a.m. and verified R38 was to be turned in bed every 2 hours. At this time, R38 was turned to her left side to receive cares. (3 hours and 15 min without repositioning).         At 1:02 p.m. RN-A verified R38 was to be repositioned every 2 hours while in bed. RN-A verified the repositioning schedule for R38 while in bed was not addressed on the POC.         The Care Planning policy revised on 1/2009, directed staff to develop a comprehensive care plan for each resident. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP         The resident has the right, unless adjudged incompetent or otherwise found to be	AS FOR MEDICARE & MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIF A. BUILDING         PROVIDER OR SUPPLIER       245512       B. WING	OP DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLA       (X2) MULTIPLE CONSTRUCTION         PROVIDER OR SUPPLIER       245512       B. WING         ARE LIVING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       B. WING         IEACH DEFICIENCY MIST BE PRECEDED BY FULL       B. WING         REQUIRE TOWN OR LSC IDENTIFYING INFORMATION)       PRETX         Continued From page 13       GRAD FROM CONSTRUCTION SHOUL         and required two staff extensive assistance for transfers and bed mobility.       F 279         R38's current POC dated 8/28/13, indicated R38 was at risk for pressure ulcers and directed staff to assist with repositioning and officading (pressure relief) every hour during awake hours, however, the POC lacked indication of the frequency R38 was to be turned and repositioned while in bed.         On 9/5/13, R38 was observed continuously in bed on her back from 7:05 a.m. until 10:15 a.m.       At 10:15 a.m. NA-C stated R38 was placed on her back from 7:05 a.m. until 10:16 a.m.         At 1:02 p.m. RN-A verified R38 was trisk for PU's. RN-A stated R38 was to be repositioned write the first dot preceive cares. (3 hours and 15 min without repositioning).       F 280         The Care Planning policy revised on 1/2009, directed staff to develop a comprehensive care planning sol-dule for R38 while in bed was not addressed on the POC.       F 280         The Care Planning policy revised on 1/2009, directed staff to develop a comprehensive care planning sol-dule for R38 while in bed was not addressed on the POC.<

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NC</u>	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				TE SURVEY MPLETED
		245512	B. WING			09	/06/2013
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER				00 HILLIGOSS BOULEVARD SOUTHEAST OSSTON, MN 56542		
(X4) ID PREFIX TAG	(ÉACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	changes in care an A comprehensive o within 7 days after to comprehensive assist interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p the resident, the resi- legal representative and revised by a tea- each assessment. This REQUIREMEN by: Based on observat review, the facility fa (POC) to accurately needs for 1 of 1 resist Findings include R29's POC dated 7/	d treatment. are plan must be developed he completion of the ressment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after IT is not met as evidenced ion, interview and document ailed to revise the plan of care reflect the oral status / care ident (R29) reviewed.	F	280	<ul> <li>CONTINUED F280-D</li> <li>B. Resident and family invited encouraged to participate in quarterly plan conferences.</li> <li>C. Chart review of all current residents were completed and charts updated to reflect residents current d status.</li> <li>D. All staff educated for compli with individual POC for all residents regarding their dental needs by Mano Licensed Staff meeting October 9 and Mandatory All Staff meeting October 2013.</li> <li>E. Education provided in an informational package to staff not atte to be completed prior to their next scheduled shift and to all new employ orientation.</li> <li>F. RNCC or her designee will a R29 oral cares weekly x 4 weeks and randomly thereafter.</li> <li>G. Random audits for all other residents will be completed weekly fo weeks then on a random basis by RN her designee to ensure ongoing completed</li> </ul>	v care were ental ance latory d 10, ending vee audit r 4 ICC or	
	Assist with oral care On 9/5/13, from 9:00 assistants (NA)-A ar provide R29 total as R29's natural teeth multiple blackened a up between them. A	ntures and directed staff to s twice a day and as needed. D a.m. to 9:30 a.m. nursing nd NA-C were observed to sistance with morning cares. were observed to have areas with white matter build t 9:27 a.m. NA-C offered R29 at no time was R29 offered			with care plan updates. H. Compliance reported to QAF meetings quarterly.		

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

Facility ID: 00461

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED OMB NO 0938-0391

CENTE	AS FOR MEDICARE	& MEDICAID SERVICES					0930-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245512	B. WING			09/	06/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER				OSSTON, MN 56542	<u></u>	
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa an opportunity to br On 9/5/13, at 9:40 a	ush his teeth. a.m. NA-C assisted R29 with	F	280			
	was wheeled to the morning activities. At 10:15 a.m. NA-C teeth and verified o	ing room. At 10:10 a.m. R29 main lobby to participate in confirmed R29 had his own ral cares had not been d during morning cares.					
	(DON) asked NA-A NA-A reported R29 majority of his teeth confirmed R29's PC reflected R29's curr	a.m. the director of nurses what type of teeth R29 had. may have a partial, but the were natural. The DON DC had not accurately rent oral status / needs and would have been completed.					
F 282 SS=E	directed staff to con for each resident qu the plans of care wi 483.20(k)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED	F2	282	It is the policy of FCLC to follow the residents' plan of care.		
	must be provided by	ed or arranged by the facility y qualified persons in ch resident's written plan of			<ul> <li>A. Written warning and counseli was completed on September 9, 2013 both staff members that were in the roduring the cares with resident R15.</li> <li>B. Comprehensive assessments</li> </ul>	with om	
	by: Based on observat review, the facility fa accordance with the	IT is not met as evidenced ion, interview and document ailed to provide services in resident's written plan of 4 residents (R15) who were			reviewed and care plans revised as appropriate for residents R55, R38 wh required assist with repositioning ident as risk for pressure ulcers.		

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

Facility ID: 00461

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If continuation sheet Page 16 of 62

STATEMEN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			B NO. 0938-039 (3) DATE SURVEY COMPLETED
		245512	B. WING		09/06/2013
NAME OF	PROVIDER OR SUPPLIEF	}	1	STREET ADDRESS, CITY, STATE, ZIP CODE	
FIRST C	ARE LIVING CENTE	R		000 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 282	observed for perin provide ambulation POC for 1 of 1 res ambulation; the fa- incontinence care residents (R38, R2 incontinence care, provide reposition of 5 residents (R33 at risk for pressure Findings include: INCONTINENCE (R38 was admitted ulcer on her ankle arterial disease an (PVD) a circulatory R38's The current staff to check R38 hours during the d On 9/5/13, from 7: was continuously of bed. At 10:09 a.m. nurs entered R38's roor assigned to R38's At 10:15 a.m. NA-0 changed at 7 a.m. urine at that time. I be changed every At 10:20 a.m. NA-0	<ul> <li>eal care; the facility failed to n services according to the sident (R13) reviewed for cility failed to provide according to the POC for 3 of 3 29, R15) reviewed for . In addition, the facility failed to ing according to the POC for 2 8, R55) in the sample identified a ulcers.</li> <li>CARE: on 9/12/12, with a pressure and upper back. R38 also had depripheral vascular disease y problem.</li> <li>POC dated 7/3/13, directed 's incontinent product every 2-3 ay.</li> <li>05 a.m. until 10:09 a.m. R38 observed asleep on her back, in</li> <li>ing assistant (NA)-A and NA-C m. Both verified there were wing (South wing)</li> <li>C stated R38s brief was and R38 was incontinent of NA-C stated R38's brief was to</li> </ul>	F 282	CONTINUED F282-E C. Comprehensive assessments reviewed and care plans revised as appropriate for residents R15, R29, R33 required assist with incontinence cares. D. Comprehensive assessment reviewed and care plan revised for reside R13 who requires assist with ambulatio E. All staff educated for complian regarding following the plan of care for residents by Mandatory Licensed Staff meeting October 9, 2013 and Mandator Staff Meeting October 10, 2013. F. Education provided in an informational package to staff not attend to be completed prior to their next schea shift and to all new employee orientation G. RNCC or her designee will au compliance of plan of care for R55, R33 R29, R13, R15 weekly x 4 weeks, then randomly thereafter. H. Random audits for all other residents will be completed weekly x 4 w then on a random basis by RNCC's or t designee to ensure ongoing compliance repositioning, incontinence cares, and ambulation program according to care I. Compliance reported to QAPI meetings quarterly	dent n. ce all y All ding duled n. dit 8, weeks heir e with

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		e survey IPleted
		245512	B. WING		09/	06/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 900 HILLIGOSS BOULEVARD FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	CTION SHOULD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ge 17	F 28	32		
	incontinent product	ered nurse (RN)-A stated R38's was to be changed every 2-3 y. RN-A verified the POC was				
	REPOSITIONING:					
	risk for PU's. RN-A	o.m. RN-A verified R38 was at stated R38 was to be en up in the wheelchair.				
		6 a.m. until 10:53 a.m. R38 oserved seated in her				
	the wheelchair at 8: NA-A were the prim verified R38 had no was assisted into th	stated R38 was assisted into 20 a.m. NA-B stated her and ary NAs for R38. NA-B t been repositioned since she e wheelchair. NA-B confirmed sitioned every hour when in				
	stand / offload R38. without repositioning	and NA-B were observed to (2 hours and 35 minutes g). ioned as directed by the				
	history of pressure u	10/13, indicated R55 had a licers and directed staff to sitioning every two hours and				
	observed seated in I assistance with repo	5 a.m. to 9:50 a.m. R55 was her wheelchair without sitioning. At 9:50 a.m. NA-A rved to assist R55 to bed via				

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

Facility ID: 00461

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		AND HUMAN SERVICES						FORM	: 09/27/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		PLE CONSTRUCTION G	<u>.</u> .	(X3) DAT	E SURVEY IPLETED
		245512		B, WING	i			09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER		nyanta takan ta			STREET ADDRESS, CITY, STATE, ZIP	CODE		
						900 HILLIGOSS BOULEVARD SOL	ITHEAST		
FIRST C	ARE LIVING CENTER					FOSSTON, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
	a full body mechani observed to be equ redistribution cushic was observed to be On 9/5/13, at 10:00 had been assisted of had not received as since that time. A to earlier. On 9/5/13, at 12:40 risk for the develop was to repositioned directed Perineal and Inconti R15 did not receive incontinence cares a greater than 4 hours R15's POC dated 8/ total assistance of 1 directed staff to prov two hours On 9/5/13, a 7:05 a. in a wheelchair. At to the dining room for R15 wheeled out of hallway to the main fall asleep in the whi lobby and without re a.m. NA-C stated ot assisted R15 out of confirmed R15 had incontinence cares a	cal lift. R55's wheelchair v ipped with a pressure on. A skin protective dress intact over the left hip. a.m. NA-A confirmed R55 but of bed at 7:00 a.m. and isistance with repositioning otal of 2 hours and 50 min p.m. RN-A stated R55 wa ment of pressure sores an every two hours as the PC inence cares: assistance with perineal of as the POC directed for s on the morning of 9/5/13 (13/13, indicated R15 requ -2 staff for perineal cares vide incontinence cares ev m. R15 was observed sea 7:50 a.m. R15 was assisted or breakfast. At 8:24 a.m the dining room and dowr lobby. R15 was observed eelchair while in the main eceiving assistance. At 10 her staff members had bed around 6:30 a.m. Sho not been assisted with since that time. NA-C and	sing 5 5 5 9 utes s at d OC or	F2	282				
		R15 to bed via a full body			Fa	acility ID: 00461	continuatio	n sheet F	Page 19 of 62

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:		NG	CO	MPLETED
		245512	B. WING		09	0/06/2013
VAME OF I	PROVIDER OR SUPPLIER	<u>Sena para di una angla sera di </u>		STREET ADDRESS, CITY, STATE, ZIP		
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SO FOSSTON, MN 56542	JTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
F 282	an incontinence pro urine. NA-A remov applied a fresh brie observed to receive cares. At 10:40 a.m. NA-0 received assistance between 6:30 am. a hours and 3 minute R15 had not receive an incontinent episo On 9/5/14, at 12:35 received incontinen and perineal cares as directed by the F Ambulation: R13's POC dated 8 assist R13 to a star four prong cane to a 40 feet or more 2-3 On 9/4/13, at 4:03 p walk all of the time, because he required Review of Ambulatio following information	5 was observed to be wearing oduct which was saturated with ed the saturated brief and f. At no time was R15 e assistance with perineal C confirmed R15 had not e with incontinence cares and 10:33 p.m. a total of 4 s. In addition NA-C confirmed ed perineal cares after having ode. p.m. RN-A stated R15 was to ce cares every two hours, after each incontinent episode POC. /28/13, directed two staff to ading position and to use a assist R13 to ambulate up to b times per week. o.m. R13 stated he used to but had not walked as much d assistance with ambulation. on Roster identified the n. - 6/14/13, R13 ambulated five	F 2	82		
	feet.	s carrying from 10 feet to 50 3 - 6/21/13, R13 ambulated 20				

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Facility ID: 00461

If continuation sheet Page 20 of 62

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MUL	TIP		(X3) DAT	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NNG		CON	IPLETED
		245512	B, WING			09/	/06/2013
NAME OF I	PROVIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTE	R			900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFL TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	Continued From	5ade 20	F 2	282			
. 202	feet on one occas	-			-		
		/13- 7/5/13, R13 ambulated 25					
	feet on one occas	sion.					
	feet on one occas	3 - 7/12/13, R13 ambulated 15					
		/13 - 7/19/13, R13 did not					
	ambulate.	to zooto Dio dia not					
	ambulate.	/13 - 7/26/13, R13 did not					
		/13 - 8/3/13, R13 ambulated 35					
	feet on once occa						
	The week of 8/4/1	3- 8/10/13, R13 ambulated 3 es varying from 10 feet to 100					
	feet.	les varying nom to toot to too					
		13- 8/17/13, R13 ambulated 13					
	feet one time. The week of 8/18, 100 feet one time	/13 - 8/24/13, R13 ambulated					
		/13 - 8/31/13, R13 ambulated 3					
	times with distance	es varying from 50 feet to 200					
	feet. The week of 9/1/1	3- 9/6/13, R13 ambulated 3					
		e varying from 55 feet to 125					
	feet.						
	On 9/6/13, at 8:10	a.m. R13 was observed to					
	ambulate with res	torative nursing assistant					
		C with licensed practical nurse with the wheelchair. R13 was					
		100 feet with assistance.					
	On 9/6/13, at 10:0	0 a.m. RN-C confirmed R13					
	had not consisten	tly received assistance to					
	ambulate as the P	OC directed.					
	Incontinence care	s and repositioning:					
	R29 did not receiv						•

		AND HUMAN SERVICES				FORM	: 09/27/2013 APPROVED . 0938-0391
STATEMEN	RS FOR MEDICARE OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .			(X3) DAT	E SURVEY
		245512	B. WING	·		09/	/06/2013
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIDOT O				9	00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER			F	OSSTON, MN 56542		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	incontinence cares	ge 21 and repositioning on the as directed by the POC.	F 2	282			
		/17/13, directed staff to assist ares and repositioning every					
	on his back. R29 wa back until 9:10 a.m. were observed to pr	Lm. R29 was observed in bed as observed to remain on his at which time NA-A and NA-C rovide R29 with morning rerved to be incontinent of kin.					
	been last assisted w	.m. NA-C stated R29 had vith incontinence cares at 6:00 rs and ten minutes earlier.					
	receive assistance	o.m. RN-A stated R29 was to with incontinence cares and two hours as directed by the					
F 311 SS=D	directed staff to follo safety for the reside	policy revised on 1/09, by the plan of care to ensure nt, staff members and facility. MENT/SERVICES TO N ADLS	F 3	i	It is the policy of FCLC to ensure treatm services to improve/maintain resident A		
	services to maintain	ne appropriate treatment and or improve his or her abilities oh (a)(1) of this section.			A. Review of comprehensive assessment, therapy recommendations care plan updated as appropriate for res R13.		
	by:	T is not met as evidenced on, interview and document			B. RNCC or her designee wil aud ambulation program weekly x 4 weeks randomly thereafter.		
DRM CMS-250	57(02-99) Previous Versions C	Dbsolete Event ID:53NP11		Faci	lity ID: 00461 If continuation	sheet F	Page 22 of 62

		AND HUMAN SERVICES				FORM	09/27/2013 APPROVED 0938-0391
STATEMEN	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · .		LE CONSTRUCTION		E SURVEY
		245512	B. WING	i		09/	06/2013
NAME OF	PROVIDER OR SUPPLIER	<b>General Constant and Constant (Charles Constant Constant Constant Constant Constant Constant Constant Constant</b>			STREET ADDRESS, CITY, STATE, ZIP CODE 000 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER			1	FOSSTON, MN 56542		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 311	review, the facility fa services according 1 resident (R13) in f Findings include: R13's diagnoses ind shortness of breath disease. The quart dated 8/20/13, indic intact and required of mobility, transfer an The Quarterly Reviet indicated R13 was a two staff using a gai The form also indica became anxious wh encouragement R13 R13's plan of care ( two staff to assist hi to use a four prong of ambulate up to 40 fo week. On 9/4/13, at 4:03 p walk all of the time, much now because ambulation. Review of Ambulatio following information The week of 6/8/13 times with distances feet.	ailed to provide ambulation to the assessed need for 1 of the sample. cluded muscle weakness, and peripheral vascular erly Minimum Data Set (MDS) ated R13 was cognitively extensive assistance for bed d ambulation. ew form dated 8/20/13, able to ambulate with assist of it belt and a four prong cane. ated R13 had occasionally then ambulating but with 3, was able to ambulate. POC) dated 8/28/13, directed m to a standing position and cane to assist R13 to set or more 2-3 times per .m. R13 stated he used to but he had not walked as he required assistance with	F	311	CONTINUED F311-D C. RNCCs or their designee will the restorative aide documentation mo to ensure ambulation programs of all residents have been completed accord plan of care. D. All staff educated for expectat with compliance with ambulation/restor program by Mandatory Licensed Staff Meeting October 9 and Mandatory All S meeting October 10, 2013. E. Education provided in an informational package to staff not atter to be completed prior to their next scheduled shift and to all new employe orientation. F. Compliance reported to QAPI meetings quarterly.	In the second se	

Facility ID: 00461

If continuation sheet Page 23 of 62

DEPARTMENT OF HEALTH AND HUMAN SERVICES       FOR         CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB N         STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         A. BUILDING       CO	D: 09/27/20 M APPROVE 0. 0938-03 ATE SURVEY DMPLETED 9/06/2013 (X5) COMPLETIO
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) D         AND PLAN OF CORRECTION       10ENTIFICATION NUMBER:       A. BUILDING       Cd         245512       B. WING       B. WING       0         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       900 HILLIGOSS BOULEVARD SOUTHEAST         FIRST CARE LIVING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       900 HILLIGOSS BOULEVARD SOUTHEAST         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         FREFIX       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 311       Continued From page 23       F 311       F 311	ATE SURVEY DMPLETED 9/06/2013
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       FIRST CARE LIVING CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       (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)       F 311     Continued From page 23     F 311	(X5)
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       FIRST CARE LIVING CENTER     900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542       (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 ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 311     Continued From page 23     F 311	(X5)
FIRST CARE LIVING CENTER     FOSSTON, MN 56542       (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)       F 311     Continued From page 23     F 311	(X5)
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 311       Continued From page 23       F 311	(X5)
	DATE
<ul> <li>The week of 6/29/13- 7/5/13, R13 ambulated 25</li> <li>feet on one occasion.</li> <li>The week of 7/6/13 - 7/12/13, R13 ambulated 15</li> <li>feet on one occasion.</li> <li>The week of 7/13/13 - 7/19/13, R13 did not ambulate.</li> <li>The week of 7/20/13 - 7/26/13, R13 did not ambulate.</li> <li>The week of 7/20/13 - 7/26/13, R13 did not ambulate.</li> <li>The week of 7/27/13 - 8/3/13, R13 ambulated 35</li> <li>feet on once occasion.</li> <li>The week of 7/27/13 - 8/3/13, R13 ambulated 35</li> <li>feet on once occasion.</li> <li>The week of 7/27/13 - 8/3/13, R13 ambulated 35</li> <li>feet on once occasion.</li> <li>The week of 8/4/13 - 8/10/13, R13 ambulated 35</li> <li>feet on once occasion.</li> <li>The week of 8/11/13 - 8/17/13, R13 ambulated 31</li> <li>feet one time.</li> <li>The week of 8/11/13 - 8/17/13, R13 ambulated 13</li> <li>feet one time.</li> <li>The week of 8/18/13 - 8/24/13, R13 ambulated 13</li> <li>feet one time.</li> <li>The week of 8/15/13 - 8/31/13, R13 ambulated 3</li> <li>times with distances varying from 50 feet to 200</li> <li>feet.</li> <li>The week of 9/11/13 - 9/6/13, R13 ambulated 3</li> <li>times with distance varying from 55 feet to 125</li> <li>feet.</li> <li>The Ambulation Roster documented reasons why</li> <li>R13 had not ambulated were "unable," "not available," "refused" or "was able to stand for weight bearing."</li> <li>On 9/6/13, at 8:10 a.m. R13 was observed to ambulate with restorative nursing assistant (RNA)-A and nursing assistant (AN)-C with</li> </ul>	
licensed practical nurse (LPN)-C following with the wheelchair. R13 was able to ambulate 100 feet with assistance.	
On 9/6/13, at 10:00 a.m. registered nurse (RN)-C RM CMS-2567(02-99) Previous Versions Obsolete Event ID:53NP11 Facility ID:00461 If continuation sheet	<u> </u>

TATEMEN	T OF DEFICIENCIES	XE & MEDICAID SERVICES	1 . /	PLE CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
LANC OF	PROVIDER OR SUPPLIE	245512	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/06/2013
	ARE LIVING CENTE			900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	
(X4) ID PREFIX TAG	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 311	but still had the al	bage 24 ccasionally refused to ambulate, pility to walk. RN-C stated due to ns, the staff did not have the	F 311		
	time to complete to confirmed R13 has assistance to amb	he ambulation programs. She d not consistently received pulate as directed by the POC.			
	restorative progra implemented beca stated if the comp marked as refuse have been due to unable to ambulat have a restorative stated when the d the staff had not in as to why the resid restorative progra received consistent restorative progra				
E 212	revised on 11/200 assistance to ensu highest level of rai possible.	ram, Direct Care Staff policy 2, directed the staff to provide are the resident maintain the nge of motion and mobility as	F 312	A Comprohensive assessment	
F 312 SS=D	DEPENDENT RES A resident who is a daily living receive	CARE PROVIDED FOR SIDENTS Inable to carry out activities of s the necessary services to rition, grooming, and personal	∠¥ ت ⊺	<ul> <li>A. Comprehensive assessment reviewed and care plan revision as appropriate for oral hygiene needs of resident R29.</li> <li>B. Chart review of all current res completed and charts were updated as appropriate according to individual ora hygiene needs.</li> </ul>	5
	This REQUIREME				

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

PRINTED: 09/27/2013 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	DENTIFICATION NUMBER:		NG	CON	IPLETED
		245512	B. WING			06/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SOUTH	AST	
(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 CORRI	IOULD BE	(X5) COMPLETIC DATE
F 312	by: Based on observat review, the facility fa with oral cares for 1 sample who was de hygiene. In addition perineal care for 1 of for incontinence car Findings include: R29 did not receive the morning of 9/5/1 R29's diagnoses ind behavioral disturbar anxiety. The quarte dated 5/25/13, indic cognitive impairmen assistance with all a MDS did not identify teeth. Review of the clinica type of assessment teeth. R29's plan of care (I identified R29 as ha dentures and directe cares twice a day ar On 9/5/13, from 9:00 assistants (NA)-A an provide R29 total ass R29's natural teeth v blackened areas with between them. At 9:	tion, interview and document ailed to provide assistance of 1 resident (R29) in the appendent on staff for oral , the facility failed to provide of 3 residents (R15) reviewed re. assistance with oral care on 13. cluded dementia with nees, paranoid state and orly Minimum Data Set (MDS) ated R29 had severe and required extensive totivities of daily living. The r any concerns with R29's al record did not contain any related to R29's oral cavity or POC) dated 7/17/13, ving upper and lower ed staff to assist with oral	F 3	<ul> <li>CONTINUED F312-D</li> <li>C. SSD/TREC monitors / e admission &amp; annual dental exam resident/ family preference and the in resident's charts.</li> <li>D. Nursing staff weekly or a dental condition checks on bath of E. Comprehensive assess reviewed and care plan revision appropriate for incontinence neer resident R15.</li> <li>F. RNCC or her designee or al cares weekly x 4 weeks for r and randomly thereafter.</li> <li>G. RNCC or her designee incontinence cares weekly x 4 weeks for r and randomly thereafter.</li> <li>H. Random audits for all of residents will be completed week then on a random basis by RNCC designee to ensure ongoing com oral cares and incontinent cares.</li> <li>I. RNCC will complete der assessments and bowel and blact assessments on all residents on quarterly, and with significant charts.</li> </ul>	s per racks exams al mucosa/ day. ment as ds of will audit esident R29 will audit eeks and R15. her ly x 4 weeks C or her pliance with ntal Ider admit,	

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Facility ID: 00461

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

PRINTED: 09/27/2013 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	CON	APLETED
		245512	B, WING		09	/06/2013
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		1	900 HILLIGOSS BOULEVARD SOUTHEAS	iΤ	
				FOSSTON, MN 56542		
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 312	Continued From pa		F 312			
* 016	opportunity to brush		1 012	CONTINUED F312-D J. All staff educated on oral I	avaiono	
	0.0/5/40 -+ 0-40			compliance and incontinence care		
		a.m. NA-C assisted R29 with ing room. At 10:10 a.m. R29		Mandatory Licensed Staff Meeting	-	
		main lobby to participate in		9, and Mandatory All Staff Meeting		
	morning activities.			10, 2013.		
	At 10:15 a m. NA-C	confirmed R29 had his own		K. Education provided in an		
		s had not been provided or		informational package to staff not a to be completed prior to their next s	-	
Oi ve	offered during morn	ling cares.		shift and to all new employee orient		
	On 9/5/13 at 12:50	p.m. registered nurse (RN)-A		L. Compliance reported to Q.		
	verified R29 was to	receive assistance with oral		quarterly		
		<ul> <li>She stated at no time when</li> <li>Assessment had she been</li> </ul>				
		ally look into R29's mouth.				
4 A		unaware if R29 had dentures				
		a.m. the director of nursing what type of teeth R29 had.				
	NA-A reported R29	may have a partial, but the				
		were natural. The DON				
		C had not accurately ent oral status and verified				
		ave been completed.				
	A policy regarding of not provided.	ral care was requested but				
		assistance with perineal tinent episode on 9/5/13.				•
	disorder. The signific 8/6/13, indicated R1	luded depression and anxiety cant change MDS dated 5 had severe cognitive				
		uired extensive assistance y living. The MDS also		-		

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Facility ID: 00461

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TATEMEN	OF DEFICIENCIES DF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY
		245512	B. WING			09	/06/2013
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 000 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 312	indicated R15 was and bladder. The Urinary Incont (CAA) dated 8/13/1 frequently incontine directed staff to as every two hours. The B & B H& P (B Physical) Assessm R15 as being incor and required exten use the toilet. The assist R15 with incr hours. R15's POC dated 8 with incontinence c required extensive after each incontine On 9/4/13, at 10:33 R15 to bed via a fu was observed to be product which was NA-A removed the clean brief. At no ti provide R15 with pe At 10:40 a.m. NA-C received assistance being incontinent of On 9/5/14, at 12:35	frequently incontinent of bowel inence Care Area Assessment 13, indicated R15 was ent of bowel and bladder and sist with incontinence cares owel and Bladder History and tent dated 8/6/13, identified ntinent of bowel and bladder sive assistance of two staff to assessment directed staff to assist ares every two A/13/13, directed staff to assist ares every two hours and total assistance with pericares ent episode. a.m. NA-C and NA-A assisted II body mechanical lift. R15 e wearing an incontinence observed saturated with urine. solled brief and applied a ime did the nursing assistants erineal care. confirmed R15 had not e with perineal cares after furine. p.m. RN-A stated R15 was to res after each incontinent by the POC.	F3	12			

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ATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATI	0938-039 E SURVEY PLETED
		045510	B. WING	******		
	PROVIDER OR SUPPLIER	245512	1	STREET ADDRESS, CITY, STATE, ZIP CODE	09/0	06/2013
	ARE LIVING CENTER		9	600 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 312	revised on 11/2006, manufacturer's guid	ge 28 included an undated elines which directed the staff after removing a soiled	F 312			
	incontinent product. 483.25(c) TREATM PREVENT/HEAL Pl Based on the comp resident, the facility who enters the facility who enters the facility does not develop pr individual's clinical of they were unavoidal pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observati review, the facility fa identified at risk for p timely repositioning R15, R55 and R29) for pressure ulcers. Findings include:	ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the ondition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and	F 314	<ul> <li>A. Comprehensive assessment</li> <li>reviewed and care plan revision as</li> <li>appropriate for residents R29, R38, R</li> <li>R55.</li> <li>B. Weekly skin assessments for</li> <li>residents completed on bath day by n</li> <li>staff and documented in EHR.</li> <li>C. RNCC will review tissue tole</li> <li>on admit, quarterly, with any sig chana</li> <li>and repositioning will reflect residents</li> <li>individualized needs.</li> <li>D. RNCC or her designee will a</li> <li>repositioning weekly x 4 weeks then or</li> <li>random basis by to ensue ongoing</li> <li>compliance with repositioning for residents will be completed weekly x 4</li> <li>weeks and then on a random basis by</li> <li>RNCC or her designee to ensure ongoing</li> </ul>	es. 15, r all ursing rance ge, udit on a dents	
	three hours and 15 n hours and 35 minute R38 was admitted or ankle and upper bac	epositioning assistance for ninutes on 9/5/13, and two s on 9/6/13. n 9/12/12, with a PU on her k. R38 also had arterial ral vascular disease (PVD, a		compliance with repositioning according their individualized plan of care.	וט נט	

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Event ID:53NP11

Facility ID: 00461

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

PRINTED: 09/27/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO. 093</u>	8-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCT		(X3) DATE SUF COMPLET	RVEY ED
		245512	B. WING			09/06/2	013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER			900 HILLIGOSS FOSSTON, MI	BOULEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	BE CON	(X5) APLETION DATE
	The Assessment of dated 6/20/13, indic development. The quarterly Minim 6/25/13, indicated F required two staff erepositioning and ha PU Care Area Asse indicated R38 was a directed staff to ass offloading (presure hours. The POC farepositioning needs offloading (presure hours. The POC farepositioning needs On 9/4/13, at 10:01 tired from sitting in I On 9/5/13, at 7:05 a on her back in bed, on - At 8:37 a.m. R38 value of the staff and the staff an	Pressure Sore Potential cated R38 was at risk for PU num Data Set (MDS) dated R38 was cognitively intact, xtensive assistance for ad two stage one PU's. The ssment (CAA) dated 9/5/13, admitted with PUs. POC) dated 8/28/13, at risk for pressure ulcers and ist with repositioning and relief) hourly during awake cked indication of R38's when in bed. a.m. R38 stated she did get her wheelchair. u.m. R38 was observed asleep R38 was continuously her back until 8:37 a.m. vas observed awake and ck in bed. R38 was red in bed,on her back until was awake on her back in a was still waiting to get up. akes them so long?" R38 was sly on her back until 10:09 ing assistant (NA)-A and a room. C stated her and NA-A were	F3	F. All auditing pro repositioning Licensed sta Mandatory / 2013. G. Ed informationa be complete shift and to	staff educated on the rep gram and compliance with g programs by Mandatory aff meeting on October 9 a All Staff Meeting October ucation provided in an al package to staff not atte ed prior to their next scheo all new employee orientat mpliance reported to QAF	n the and 10th, nding to luled ion.	
FORM CMS-250	37(02-99) Previous Versions	Obsolete Event ID:53NP11		Facility ID: 00461	If continuatio	n sheet Page	30 of 62

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	TIF	PLE CONSTRUCTION	F	0. 0938-0391 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				WPLETED
		245512	B. WING			. 09	/06/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	00/2010
					900 HILLIGOSS BOULEVARD SOUTHEAST	•	
FIRST C	ARE LIVING CENTER				FOSSTON, MN 56542		
(X4) ID		TEMENT OF DEFICIENCIES	ai		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
		•			DEFICIENCY)		
F 314		-	F3	314	4		
		n. and was to be turned in bed					
		is time, R38 was turned to her ares. (3 hours and 15 min					
	without repositioning						
		asked NA-A, "Why are you					
	so late?"						
		ered nurse (RN)-A stated R38					
		k for PU. RN-A stated R38 hourly when up in the					
		ry two hours while in the bed.					
		positioning schedule for R38					
		addressed on the care plan.					
	On 0/0/10 at 0/00 a	m DOD was absented in her					
		.m. R38 was observed in her eakfast table. R38 was					
	continuously observ						
		cial service designee brought					
	R38 to her room.						
	<ul> <li>At 9:35 a.m. H38 w her wheelchair in he</li> </ul>	vas observed to remain up in					
		y aide (AA)-A brought R38 to					
	exercise group in the						
	continuously observe	ed until 10:50 a.m.					
		stated her bottom was sore					
	from sitting.	3 stated R38 was assisted					
		it 8:20 a.m. NA-B stated R38					
		lioned since she was placed					
		A-B stated R38 was to be					
		our in the wheelchair.					
		was observed to be stand 's assistance for repositioning					
		s and 35 minutes without		1			
	repositioning).						
	- At 11:00 a.m. NA-B						
	repositioning occurre	ed due to understaffing.					
	R15 did not receive a	assistance with repositioning					
		hours on the morning of					
		<u>~</u>		l			J

Event ID:53NP11

Facility ID: 00461

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					<u>. 0938-0391</u>
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILD	_TIE DING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245512	B. WING			09	/06/2013
	PROVIDER OR SUPPLIER ARE LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		) BE	(X5) COMPLETION DATE
F 314	disorder. The signif 8/6/13, indicated R <sup>-1</sup> impairments and re with activities of dai indicated R15 was PUs. The PU CAA dated risk for the develop incontinence and de The Assessment of dated 8/6/13, identif the development of Assessment dated able to sit for two ho his skin. R15's POC dated 8/ risk for the develop interventions such a mattresses on the b	cluded depression and anxiety icant change MDS dated 15 had severe cognitive quired extensive assistance ly living. The MDS also at risk for the development of 8/13/13, indicated R15 was at ment of PU's due to urinary	F 3	314			
	On 9/5/13, a 7:05 a. in a wheelchair in th - At 7:50 a.m. R15 v room for breakfast. - At 8:24 a.m. R15 room and down the R15 was observed t while in the main lob assistance. At no tim	R15 was to be repositioned. m. R15 was observed seated e main lobby. vas assisted to the dining wheeled out of the dining hallway to the main lobby. to fall asleep in the wheelchair oby without receiving ne was R15 observed to be mself in the wheelchair.					

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			U.S.	IND NO	0930-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245512	B. WING			09	/06/2013
NAME OF I	PROVIDER OR SUPPLIER	<u>5</u>			STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER				900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	Continued From pa On 9/5/13, at 10:00 not received assista being assisted out of - At 10:33 a.m. NA- had assisted R15 of She confirmed R15 since that time. NA- R15 to bed via a full wheelchair was obs pressure redistribut observed to be pink ulcers. - At 10:40 a.m. NA received assistance 6:30 a.m. and 10:33 minutes. On 9/5/14, at 12:35 stated R15 was to r repositioning every R55 did not receive repositioning and ha R55's diagnoses ind	ige 32 a.m. NA-A stated R15 had ance with repositioning since of bed. C stated other staff members ut of bed around 6:30 a.m. had not been repositioned C and NA-A then assisted I body mechanical lift. R15's served to be equipped with a ion cushion. R15's skin was and intact free of pressure -C confirmed R15 had not with repositioning between 3 p.m. a total of 4 hours and 3 p.m. registered nurse (RN)-A eceive assistance with two hours.	F3	ta Purchanda			
	6/25/13, indicated F impairment and req with bed mobility, to and as being non at also indicated R55 v development of pre- dated 4/9/13, indicated	t55 had severe cognitive uired extensive assistance tal assistance with transfers mbulatory. The assessment was at risk for the ssure ulcers. The PU CAA ted R55 was at risk for the ssure ulcers due to decreased					

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		3) DATE SURVE COMPLETED	
		245512	B. WING			09/06/201	3
VAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2			
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD S FOSSTON, MN 56542	OUTHEAST		
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIA		ETIO
F 314	The Assessment of dated 6/21/13, indic development of PU The Tissue Tolerand 6/21/13, indicated F to two hours withou on her skin. The Skin Risk Asse form dated 6/21/13, of PUs and required repositioning every R55's POC dated 4/	Pressure Sore Potential form ated R55 was at risk for the s. ce Assessment form dated R55 had the ability to sit for up t the development of redness ssment and Interventions indicated R55 had a history I staff to assist with two hours.	F 3				
	to assist R55 with re and as needed. The nurses note dat nursing staff had ide left hip. The first are (centimeters) and re was a 0.75 cm dry of first area. The nursind dressing (thin protect and planned to mon resolved. On 9/5/13, at 7:05 a main lobby, seated i mechanical lift shee	PUs. The POC directed staff epositioning every two hours ted 8/24/13, indicated the entified two open areas on the a was approximately 2 cm ad in color. The second area open area in the middle of the ng staff applied a Exuderm ctive dressing) over the area itor until the area had .m. R55 was observed in the n a wheelchair. A full body t was positioned under the					
	to her room by a lab - At 7:45 a.m. R55 w area.	vas observed to be assisted oratory staff member. vas returned to the lobby vas assisted to the South					

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

PRINTED: 09/27/2013 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			U	<u>WR NO</u>	0938-0391
STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE				TE SURVEY
	245512	B. WING	i	, 	09	/06/2013
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST CARE LIVING CENTER			-	00 HILLIGOSS BOULEVARD SOUTHEAST OSSTON, MN 56542		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>room to the main lob the lobby area until 9 and NA-C assisted F mechanical lift. R55's be equipped with a p cushion. A protective be intact over the left</li> <li>On 9/5/13, at 10:00 a had been assisted ou had not received ass since that time. A tota minutes earlier.</li> <li>On 9/5/13, at 12:40 p risk for the developm was to be repositione p.m. RN-A observed the protective dressin refused to remove the skin at that time.</li> <li>On 9/6/13, at 12:30 p dressing from the left the open area had rest</li> <li>R29 was identified at PUs and was not prov repositioning on the n hours and 11 minutes</li> <li>R29's diagnoses inclu behavioral disturbanc quarterly MDS dated severe cognitive impa extensive assistance</li> </ul>	as wheeled from the dining by area. R55 remained in 250 a.m. at which time NA-A R55 to bed via a full body s wheelchair was observed to ressure redistribution dressing was observed to thip. a.m. NA-A confirmed R55 ut of bed at 7:00 a.m. and istance with repositioning al of two hours and 50 b.m. RN-A stated R55 was at ent of pressure sores and ed every two hours. At 2:50 R55's left hip and identified og on the left hip. RN-A e dressing to assess R55's b.m. the DON reported the hip had been removed and solved. risk for the development of vided timely assistance with norning of 9/5/13, for three a. uded anxiety, dementia with es and paranoia. The 7/9/13, indicated R29 had	F	314			

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Facility ID: 00461

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

PRINTED: 09/27/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO. 0938</u>	<u>8-039</u>
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	TIPLE CONSTRUCTION	_	(X3) DATE SUR COMPLETE	
		245512	B. WING			09/06/20	)13
NAME OF	PROVIDER OR SUPPLIER	S		STREET ADDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	1		900 HILLIGOSS BOULEV FOSSTON, MN 56542	ARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC'	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPE FICIENCY)	BE COM	(X5) PLETIC DATE
	MDS also indicated development of PU also identified R29 PUs. R29's POC dated 7 risk for skin breakd assist with repositio The Assessment of dated 7/8/13, identi for the developmen The Skin Risk Asse form dated 7/8/13, it the development of assist with repositio sitting or supine. On 9/5/13, at 7:10 a bed on his back. R2 bed, on his back un was observed to red cares. R29's skin w 9:20 a.m. R29 was full body mechanica NA-A and NA-C. On 9/5/13, at 9:40 a been last assisted v a total of 3 hours an On 9/5/13, at 1:00 j	ssistance with transfers. The I R29 was at risk for the s. The PU CAA dated 4/21/13, at risk for the development of 7/17/13, indicated R29 was at own and directed staff to oning every two hours. Pressure Sore Potential form fied R29 as being at high risk t of PUs. essment and Interventions dentified R29 at high risk for PU and directed staff to oning every two hours while a. R29 was observed resting in 29 was observed to remain in til 9:10 a.m. at which time R29 ceive assistance with morning as observed to be intact. At transferred from the bed via a at lift with the assistance of a.m. NA-C stated R29 had with repositioning at 6:00 a.m. id ten minutes earlier. b.m. RN-A stated R29 was to with repositioning every two	F3				
		nt policy revised on 8/06, and		5 (B) (D) 02401	18		
RM CMS-250	67(02-99) Previous Versions	Obsolete Event ID:53NP11		Facility ID: 00461	ii continuatio	n sheet Page 3	0 01

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/27/201 APPROVE . 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		E SURVEY
		245512	B. WING_		09/	/06/2013
NAME OF	PROVIDER OR SUPPLIER	<u>Construction of the second second</u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SOUTHEAST		
			<u> </u>	FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa		F 31	4		
F 315 SS=E	directed the staff to repositioning as dire individual assessmed 483.25(d) NO CATH RESTORE BLADDI Based on the reside assessment, the fac resident who enters indwelling catheter in resident's clinical co catheterization was who is incontinent of treatment and service infections and to res function as possible This REQUIREMEN by: Based on observation review, the facility faction timely assistance with care for 3 of 4 reside the sample identified comprehensive asso Findings include: R38 was incontinent incontinence care as (POC). R38's diagnoses incontinent	HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the ondition demonstrates that necessary; and a resident f bladder receives appropriate ces to prevent urinary tract store as much normal bladder on, interview and document uled to ensure residents urinary incontinence received th toileting and incontinence ents (R38, R15 and R29) in d as incontinent based on the essment.	F 31	<ul> <li>It is the policy of FCLC to prevent UTI restore as much normal bladder function possible.</li> <li>A. Comprehensive assessment reviewed and care plan revision as appropriate for residents R29, R15, R3.</li> <li>B. RNCC or her designee will an incontinence management of R29, R1 according to their individualized plan of weekly x 4 weeks then on a random b</li> <li>C. Random audits for all other residents will be completed weekly x 4 weeks then on a random basis by RN4 her designee to ensure ongoing comp with incontinence management and individualized toileting interventions.</li> <li>D. RNCC will review/revise as appropriate bowel and bladder assess for all residents on admit, quarterly, wi significant changes in continence.</li> <li>E. RNCC or their designee will the TENA products policy and procedu incontinence management and will designed toileting programs for all residents who would benefit from these interventions.</li> </ul>	on as 38 udit 5, R38 of care asis. CC or liance ments th follow ure for sign	

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Event ID: 53NP11

Facility ID: 00461

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 245512 09/06/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION D (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 315 Continued From page 37 F 315 CONTINUED F315-E F. Education for all staff on P and P The quarterly Minimum Data Set (MDS) dated for incontinence management and 6/25/13, indicated R38 was cognitively intact. The bladder assessment dated 6/25/13, indicated R38 compliance with the individualized toileting refused a toileting program and staff continued to schedule by Mandatory Licensed Staff change incontinent brief per manufacturer's Meeting on October 9, and Mandatory All recommendations. The Urinary Incontinence Staff meeting on October 10, 2013. Care Area Assessment (CAA) dated 9/5/13, G. Education provided in an indicated R38 had episodes of bladder informational package to staff not attending incontinence. to be completed prior to their next R38's POC dated 7/3/13, directed staff to provide scheduled shift and to all new employee incontinent cares every 2-3 hours during the day. orientation. Compliance reported to QAPI Η. On 9/5/13, at 7:05 a.m. R38 was observed asleep meetings quarterly. on her back in bed. R38 was continuously observed in bed, on her back until 10:09 a.m. - At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. - At 10:11 a.m. NA-C stated her and NA-A were the NAs assigned to the South wing. - At 10:15 a.m. NA-C stated R38's brief was changed at 7 a.m. and R38 was incontinent of urine at that time. NA-C stated the R38's incontinent brief was to be changed every 2 hours. - At 10:20 a.m. NA-C changed the brief and R38's incontinent product was observed saturated with urine. (3 hours and 20 minutes after the last brief change). On 9/5/13, at 1:02 p.m. registered nurse (RN)-A stated R38 was to receive incontinence cares every 2-3 hours during the day. RN-A verified the POC was not followed.

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

Facility ID: 00461

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	F	(X3) DATE SURV	/EY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMPLETE	ַ
		245512	B. WING			09/06/20	13
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 900 HILLIGOSS BOULEVARD SO			
FIRST C	ARE LIVING CENTER			FOSSTON, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT 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 I	BE COMP	X5) PLETION ATE
F 315		ge 38 assistance with incontinence an four hours on the morning	F 31	5			
	disorder. The signif 8/6/13, indicated R1 impairment and req with activities of dai	cluded depression and anxiety icant change MDS dated I5 had severe cognitive uired extensive assistance ly living. The MDS also frequently incontinent of bowel					
	indicated R15 was f	nence CAA dated 8/13/13, frequently incontinent of bowel ected staff to assist with every two hours.					
	Physical) Assessme R15 was incontinen required extensive a	owel and Bladder History and ent dated 8/6/13, indicated t of bowel and bladder and assistance of two staff to use the staff to assist R15 with every two hours.					
		13/13, directed staff to assist ares every two hours.					
· · · · · · · · · · · · · · · · · · ·	main lobby seated in - At 7:50 a.m. R15 w to the dining room fo - At 8:24 a.m. R15 w and down the hallwa observed to fall asle	m. R15 was observed in the n a wheelchair. vas observed to be assisted or breakfast. vheeled out of the dining room ay to the main lobby. R15 was ep in the wheelchair while in out receiving assistance.					
		a.m. NA-A stated R15 had nce with incontinence since fore breakfast.			11001-1011-101-101-101-101-101-101-101-		
RM CMS-250	67(02-99) Previous Versions (	Obsolete Event ID:53NP11	Fa	acility ID: 00461 If	continuation	sheet Page 39	a of F

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		-		1	) <u>. 0938-0391</u>
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70001112		245512	B. WING			09	/06/2013
NAME OF	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FIRST C	ARE LIVING CENTER				000 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
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F 315	Continued From page	ge 39	F 3	315			
	At 10:33 a.m. NA-C had assisted R15 or She confirmed R15 incontinence cares NA-A were then obs a full body mechanic be wearing an incor saturated with urine confirmed R15 had incontinence cares I p.m. a total of four h On 9/5/14, at 12:35 receive incontinence directed by the POC R29 did not receive incontinence cares of R29's diagnoses inc behavioral disturban quarterly MDS dated severe cognitive imp extensive assistance living. The MDS also totally incontinent of Incontinence CAA da as being totally incor	<ul> <li>Stated other staff members ut of bed around 6:30 a.m. had not been assisted with since that time. NA-C and served to assist R15 to bed via cal lift. R15 was observed to ntinence product which was . At 10:40 a.m. NA-C not received assistance with between 6:30 am. and 10:33 iours and three minutes.</li> <li>p.m. RN-A stated R15 was to a cares every two hours as .</li> <li>timely assistance with on the morning of 9/5/13.</li> <li>luded anxiety, dementia with ces and paranoia. The 17/9/13, indicated R29 had pairments and required a with all activities of daily o identified R29 as being bladder. The Urinary ated 4/21/13, identified R29 ntinent of bladder.</li> <li>17/13, directed staff to assist res every two hours.</li> </ul>					
	identified R29 as beil bladder and required	ng totally incontinent of assistance of staff to cares every two hours.					

Facility ID: 00461

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PRINTED: 09/27/2013

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ATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DA CO	TE SURVEY MPLETED
			A. BUILDING	3		
		245512	B. WING		09	/06/2013
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEA	CT.	
FIRST C	ARE LIVING CENTER			FOSSTON, MN 56542	01	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 315	On 9/5/13, at 7:10 a bed on his back. R2 bed, on his back un received assistance NA-A and NA-C. R incontinent of bladd cares.	ge 40 a. R29 was observed resting in 29 was observed to remain in til 9:10 a.m. at which time R29 with morning cares from 29 was observed to be er at the time of morning a.m. NA-C stated R29 had	F 315	3	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	been last assisted w a.m. a total of three earlier. On 9/5/13, at 1:00 p receive assistance w two hours as directed The Bladder and Bo 12/05 and revised o	vith incontinence cares at 6:00 hours and ten minutes c.m. RN-A stated R29 was to with incontinence cares every ed by the POC. wel Assessment policy dated n 11/06 directed the staff if a		·		
F 323 SS=E	with the inability to n receive assistance v product check every needed. 483.25(h) FREE OF HAZARDS/SUPERV	/ISION/DEVICES	F 323	receives adequate supervision and assistance devices to prevent accid		
	environment remain as is possible; and e	sure that the resident s as free of accident hazards each resident receives n and assistance devices to		<ul> <li>A. Enabler bar assessments completed for all residents who utill enabler bars and care plan revision appropriate to reflect individualized</li> <li>B. SSD to ensure resident/fa notification of risk/benefits and pote hazards of enabler bar use.</li> <li>C. All enabler bars with expo</li> </ul>	i as needs. mily ential	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 245512 B. WING 09/06/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 323 Continued From page 41 F 323 CONTINUED F323-E Based on observation, interview and document D. IDT/ Therapy will perform review, the facility failed to ensure an enabler bar was safe to use for 2 of 2 residents (R38, R42) in environmental screen for all resident needs the sample. In addition, the facility failed to for enabler bars as a positioning device on ensure enabler bars were assessed for resident admit, quarterly, and with significant safety which had the potential to affect 17 changes. residents (R38, R42, R37, R56, R33, R20, R59, DON will audit enabler bars for E. R13, R26, R48, R23, R58, R44, R57, R6, R52, depth of openings to ensure less than 4" R2) who utilized enabler bars. between openings and for exposed bolt Findings include: heads weekly x 4 weeks and monthly thereafter on all residents utilizing enabler R38 was diagnosed with arterial disease and bars. peripheral vascular disease (PVD, a circulatory F. Education provided to all facility problem). staff on enabler bar safety by Mandatory Licensed Staff meeting October 9 and The guarterly Minimum Data Set (MDS) dated Mandatory All staff meeting October 10, 6/25/13, indicated R38 was cognitively intact and required extensive assistance of two staff for bed 2013. mobility and transfers. G. Education provided in an informational package to staff not attending R38's plan of care (POC) dated 7/3/13, indicated to be completed prior to their next scheduled R38 used enabler bars on the bed to increase her shift and to all new employee orientation. bed mobility. H. Compliance reported to QAPI meetings quarterly. On 9/4/13, at 9:59 a.m. bilateral enabler bars were observed on R38's bed. In the center of the rail a horizontal PVC pipe (a combination pipe made from plastic and vinyl) was observed which ran left to right on the bar. The PVC pipe had 2 screws on the end of the enabler bar that were sharp to the touch. R38 stated the rails were sharp and stated a couple of times she had sustained skin tears from the rails. An undated incident report indicated a nursing assistant (NA) observed a skin tear on R38s right upper arm covered with dried blood. After cleansing, it was noted there were three separate FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:53NP11 Facility ID: 00461 If continuation sheet Page 42 of 62

IND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245512       B. WING         INAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         FIRST CARE LIVING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         (X) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         F 323       Continued From page 42 tears in a row with the one closest to the elbow which measured 1.0 centimeter (cm), next 0.5 cm and at the top there was a "V"-shaped tear measuring 0.75 cm on each side of the "V."       F 323         On 8/9/13, the nursing progress notes indicated a NA had observed a skin tear on R38's upper outer arm. Had dried blood over the area and was difficult to cleanse adequately due to fragile skin. The note indicated the NA had asked R38 how this had occurred and the resident stated she had bumped her arm on her enabler baz during the previous night. The note also indicated there were three tears in a line. This was documented by licensed practical nurse (LPN)-D.       On 9/6/13 at 9:47 a.m. LPN-B verified the 8/9/13, incident report was undated when printed. LPN-B stated the entry for the incident report was date stamped on the computer, LPN-B then printed the corresponding nursing progress note.       On 9/6/13 at 10:10 a.m. the director of nursing (DON), stated she had not realized R38's skin tears were from the enabler baz. The DON stated LPN-D had not documented on the incident report	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       FIRST CARE LIVING CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       (xi) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       F 323     Continued From page 42 tears in a row with the one closest to the elbow which measured 1.0 centimeter (cm), next 0.5 cm and at the top there was a "V"-shaped tear measuring 0.75 cm on each side of the "V."     F 323       On 8/9/13, the nursing progress notes indicated a NA had observed a skin tear on R38's upper outer arm. Had dried blood over the area and was difficult to cleanse adequately due to fragile skin. The note indicated the NA had asked R38 how this had occurred and the resident stated she had bumped her arm on her enabler bar during the previous night. The note also indicated there were three tears in a line. This was documented by licensed practical nurse (LPN)-D.       On 9/6/13, at 9:47 a.m. LPN-B verified the 8/9/13, incident report was undated when printed. LPN-B stated the entry for the incident report was date stamped on the computer. LPN-B then printed the corresponding nursing progress note.       On 9/6/13 at 10:10 a.m. the director of nursing (DON), stated she had not realized R38's skin tears were from the enabler bar. The DON stated	(X5) E COMPLETIC
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I LEN-U 130 NOT DOCUMENTED ON THE INCIDENT TEDOT	
the skin tears were from the enabler bar and	
stated she would have had to read the nurses	
notes to know it was from the enabler bar.	
On 9/6/13, at 10:32 a.m. the social service	
designee (SSD) stated she had spoken with R38	
after the incident and R38 had told the SSD she had been bumped on the enabler bar .	
R42's diagnoses included explosive personality	
disorder and depression. The quarterly MDS	
dated 8/6/13, indicated R42 had moderate cognitive impairment and required extensive	1

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 245512 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST **FIRST CARE LIVING CENTER** FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES **PROVIDER'S PLAN OF CORRECTION** (X5) COMPLETION ID. (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 43 F 323 assistance with activities of daily living including bed mobility. The Pressure Ulcer Care Area Assessment (CAA) dated 5/22/13, indicated R42 utilized enable bars on the bed to assist in turning and repositioning. The CAA also indicated R42 was was able to turn from side to side in the bed independently and required extensive assistance to go from a supine to sitting position. R42's POC dated 2/27/13, indicated R42 utilized bilateral enable bars to aid with turning repositioning and bed mobility and to aide in independence. The Alternative Device form dated 4/26/13, identified R42 as having enabler bars in place. The reason for the bars and the date which they were placed was not identified on the form. The form stated the bars were in place prior to the implementation of the Alternative Device form which was started on 4/26/13. On 9/3/13, at 6:10 p.m. R42's bed was observed to be equipped with two large "U" shaped enabler bars. The bars were observed to have been adapted with one PVC pipe that ran from left to right on the bar. The space which the PVC pipe created between the pipe and the bed frame was large. The edges of the pipe were held in place with screws which were sharp to the touch and the edges of the pipe were not secure to the inner aspect the bar causing it to move up and down, exposing rough edges of the pipe. On 9/5/13, at 2:15 p.m. RN-A stated the maintenance department had visualized the enabler bars to ensure appropriate size for resident use. RN-A stated she was aware R42 Event ID:53NP11 FORM CMS-2567(02-99) Previous Versions Obsolete

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#### (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED. IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 245512 B. WING 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 323 F 323 Continued From page 44 used his bars for bed mobility, but at no time did the facility complete assessments on the bars to ensure they were safe for the residents. At 2:30 p.m. RN-A measured the spaces between the PVC pipe and the bed frame. RN-C reported the space was greater than 8.0 inches. RN-C verified the tape around the main U shape on the right bar was peeling away and that the screws and edges of the PVC pipe were rough and residents could potentially become injured. The Federal Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment guidance to Reduce Entrapment dated 3/10/06, indicated the space between the bed rails was not to exceed 4 3/4 inches. On 9/6/13, at 9:20 a.m. maintenance staff member (MS)-A stated when ordered by the facility, the enabler bars were large U shaped bars with no additional bars in them to decrease the space between the rails. He explained the facility staff members had added two PVC pipes to each of the rails to ensure the space between the rails did not exceed 4 3/4 inches. He stated he was unaware why R42's rails only had one PVC pipe. He stated it should have two PVC pipes. On 9/6/13, at 9:30 a.m. the director of environmental services (DES) stated the facility had purchased several rails about seven years ago. The DES stated the facility had required more rails over the years therefore, some of the

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maintenance staff had fabricated matching rails. He explained the PVC pipes had been added to all of the rails to decrease the spaces for potential entrapment. He stated all of the rails with a singe PVC pipe should have been removed and they

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PRINTED: 09/27/2013

OMB NO. 0938-0391

FORM APPROVED

(X5) COMPLETION DATE

#### OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 245512 B. WING 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAG TAG DEFICIENCY) Continued From page 45 F 323 F 323 should all be equipped with two PVC pipes. He stated the facility did not have any manufacture documentation regarding the rails and stated all of the original manufactured rails had been altered in an attempt to reduce the rails. The DES added the facility was currently in the process of reviewing new bed options which were equipped with enabler bars and they had received approval for them. However, they were not currently in house and alternative enabler bars were not available. On 9/6/13, at 12:00 p.m. licensed practical nurse (LPN)-A provided a list which identified the facility currently had 17 resident beds equipped with enabler bars which had either been altered from the manufacturer's original design or fabricated by staff. The list indicated R38, R42, R37, R56, R33, R20, R59, R13, R26, R48, R23, R58, R44, R57, R6, R52, and R2 all had altered rails on their beds. The 1/2 side Rail/Enabler Use in LTC (long term care) policy dated 7/11, directed the staff to assess the resident upon admission for the use of 1/2 side rails/enablers. The policy did not direct the staff to ensure the rails were safe for the residents. F 353 483.30(a) SUFFICIENT 24-HR NURSING STAFF F 353 PER CARE PLANS SS≂F It is the policy of FCLC to ensure adequate productive nursing staff and nursing The facility must have sufficient nursing staff to assistants each shift in compliance with provide nursing and related services to attain or state and federal regulations. maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 245512 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 353 Continued From page 46 F 353 CONTINUED F353-F The facility must provide services by sufficient Standardized nursing day will be Α. numbers of each of the following types of audited weekly by HUC and DON. This is personnel on a 24-hour basis to provide nursing the sum of the number of residents in each care to all residents in accordance with resident case mix class x the case mix weight for that care plans: class, calculated on the basis of a facility's Except when waived under paragraph (c) of this census. Calculation of nursing hours is section, licensed nurses and other nursing performed by dividing total hours of nursing personnel. personnel by the standardized resident davs. Except when waived under paragraph (c) of this Β. Budgeted staffing averages at 5.1 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of direct care staff hours per resident days. duty. C. Case mix calculations will be done weekly, and with each admit or case mix change to ensure proper number of staff This REQUIREMENT is not met as evidenced person scheduled. by: D. Challenges with staffing Based on observation and interview, the facility emergencies will be handled by adjusting failed to ensure sufficient qualified nursing staff were available to meet the residents' needs for staff. Direct care staff to notify all available nursing care in a manner which promoted each licensed staff to assist with resident care. resident's physical, mental and psychosocial COTA and PTA will assist with restorative well-being, thus enhancing their quality of life. nursing duties. Unlicensed personal will This practice had the potential to affect all 47 assist with housekeeping/bed making. residents residing in the facility. Ε. Weekly case mix reports to Clinical Services Director and Administrator. Findings include: F. Education provided to all facility During the survey conducted on 9/3/13, from staff on staffing interventions by Mandatory 11:30 a.m. until 8:00 p.m. and 9/4/13, from 8:00 Licensed Staff meeting on October 9, and a.m. until 4:30 p.m. 9/5/13, from 7:00 a.m. until Mandatory All Staff Meeting on October 10, 3:30 p.m. and on 9/6/13, from 8:00 a.m. until 4:30 2013 p.m. respectively, staff were observed to not be able to consistently provide services for the residents as directed by their plans of care based on a comprehensive assessment of their needs. The facility failed to provide timely meals in a

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Event ID: 53NP11

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1				(X3) DATE SURVEY COMPLETED	
245512			B, WING			09/	06/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER				FOSSTON, MN 56542		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
	manner which prom residents (R13, R29 not receive breakfas The facility failed to according to the ass resident (13) in the The facility failed to risk for pressure ulce repositioning for 4 of and R29) in the sam pressure ulcers. See The facility failed to risk for urinary incon assistance for 3 of 4 R29) in the sample in based on the compre F315. Staffing reports were five weeks. (8/1/13 pattern determined the nursing assistants (N work as NA and as a to complete restoratific designated to assist licensed nurses routific administration, docum non-direct care nursis to assist NAs with the necessary. The evening shift sta	oted dignity for 3 of 3 b, R15) in the sample who did st. See F241. provide ambulation services sessed need for 1 of 1 sample. See F311. ensure a resident identified at ers (PU) received timely f 5 residents (R38, R15, R55 ple identified at risk for $\Rightarrow$ F314. ensure residents identified at tinence received timely residents (R38, R15 and dentified as incontinent ehensive assessment. See e reviewed for the previous = 9/6/13). The facility staffing he day shift required two IA), two nursing assistants to universal worker, two NAs ve exercises and one NA residents with baths. Two	F 3	353		eduled ion.	
		along with two licensed					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

		1 · ·	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245512	B. WING		09	/06/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SOU FOSSTON, MN 56542	THEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 48	F3	53		
	The night shift cons two NAs.	sisted of one licensed staff and				
	days of which 12 da and 20 days (8/1, 2 22, 23, 25, 26, 27, 2 staff had shortages September from 9/ daily staffing shorta projected nursing s the facility had six d	for August 2013, identified 31 ays were without shortages , 3, 4, 5, 7, 8, 9, 11, 16, 17, 20, 29, 30, 31) nursing assistant of 1 - 3 staff members. In 1/13 - 9/6/13, the facility had ges of 1-3 staff. Of the chedule from $9/7/13 - 9/22/13$ , lays (9/9, 12, 14, 15, 17, 18) in taff were to work with 1 -2 short.				
	resident, reported th staffed in the mornin like to get up around	o.m. R59 an alert and oriented ne facility was frequently short ng. R59 explained he would d 6:30 a.m. but the facility did nough staff to help him.				
	resident stated it too	o.m. R47, an alert and oriented ok a long time for the staff to morning, but felt that was part home.				
	with five nursing ass two medication nurs the facility, licensed assisted in the dinin (RN)-A, LPN-D/soci director of nurses (E assist the NAs who On 9/5/13, at 12:04	I.m. the facility was staffed sistants (instead of seven) and ses. As support staff arrived at practical nurse (LPN)-A g room. Registered nurse al service designee, and the DON) were not observed to were providing direct care. p.m. NA-C stated the facility				
		assistant and she was stated when the support staff Obsolete Event ID:53NP11		Facility 1D: 00461 If c	continuation sheet	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 245512 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION iD (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 353 F 353 Continued From page 49 such as the registered nurses doing paper work, the licensed practical nurses (LPN) who worked as the social service designee and the ward clerk and the director of nurses arrived at the facility, they did not check in with the staff on the floor to see how things were going. NA-C stated they may check in with the wing nurses and LPN-A assists with the dining room, but they do not routinely assist with providing cares on the floor. NA-C stated the facility was frequently short staffed. NA-C added she and NA-A had 22 residents assigned to them to provide morning cares to. Of those 22 residents, 13 of the residents required assistance of two staff for some or all of the morning cares and only two residents were completely independent with their morning routine. On 9/5/13, at 12:11 p.m. NA-A stated the facility has been short staffed for the past few weeks. He stated the nursing staff will help when they can but they do not consistently ask if the NAs on the floor need help. On 9/5/13, at 12:20 p.m. LPN-A stated each morning she assists the residents in the north dining room and will help the staff whenever she had a chance. She stated she was aware at 7:30 a.m. that the staff on the floor were two nursing assistants short, but she was unable to help due to meeting. On 9/5/13, at 12:44 p.m. RN-A stated she had arrived at the facility at 8:40 a.m. and had been made aware the facility was two NAs short. She stated on a regular day she would be informed about such concerns around 10:00 a.m. during morning report. She stated she could easily help the staff on the floor but had not been asked to Facility ID: 00461 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 53NP11 If continuation sheet Page 50 of 62

		AND HUMAN SERVICES			FORM	): 09/27/2013 / APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245512	B. WING_		09	/06/2013
NAME OF	PROVIDER OR SUPPLIER	NY NY INY TANÀ AMIN'NY TAONA 2008–2008–2014. Ilay kaominina dia mampika dia kaominina dia mampika dia kaominina		STREET ADDRESS, CITY, STATE, ZIP CODE	**	*****
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SOUTHEAS FOSSTON, MN 56542	ı	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 353	assist. She stated s morning of 9/5/13, b stated the facility ha patterns and the cha staff as they could to cover the shift. On 9/5/13, at 1:00 p the South cart state. NAs on the floor as LPN-A usually helpe licensed nurse did n asked. On 9/5/13, at 1:15 p who requested to re facility was short sta staff member explain facility had 17 shifts death, one planned admissions. The sta licensed staff (LPN-/ DON) may check in	he was unable to assist the because of a meeting. She id occasional short staffing arge nurses called as many o try to find assistance to LPN-C who was working d the LPN's try to help the much as possible. She stated ed with meals, but the other tot consistently help unless a nursing staff member main anonymous stated the ffed quite frequently. The ned that in the past week, the which were not filled, one discharge and five new ff member stated the support A, LPN-D/SSD, RN's and with the charge nurses, but	F 35	53		
	they do not assist wi LPN-A would assist On 9/6/13, at 7:16 a. had four NAs, a bath The facility was shor On 9/6/13, at 7:43 a. stated she ended up nursing assistant 2-3 direct care for the re- not consistently able cares because of pro-	th cares. The staff stated				

Event ID:53NP11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245512		B. WING	B. WING			/06/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SOI FOSSTON, MN 56542	JTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD I	3E	(X5) COMPLETION DATE
F 353	stated the facility wa difficult transition du some staffing chang the DON did not lea When questioned a short, the DON did based on the statist still meeting the new questioned if the cu cares, she stated sh concerns. The DON days, the facility had death and four new the staffing pattern,	ge 51 d the staffing patterns. She as currently going through a ie to employee illness and ges. She explained LPN-A and ve the facility "short short." s to the definition of short not respond. She explained ical findings, the facility was ds of the residents. When rrent residents were receiving the was unaware of any confirmed in the past seven one planned discharge, one admissions. Upon review of the DON confirmed the ently meeting the established	F3	53			
F 411 SS=D	assisted the staff on assisted with filling t of the staff assist wi according to the staff was meeting the req A policy regarding st but not provided. 483.55(a) ROUTINE SERVICES IN SNFS The facility must ass routine and 24-hour A facility must provid resource, in accorda part, routine and em- meet the needs of ea	ufficient staff was requested, /EMERGENCY DENTAL	F 4 <sup>-</sup>	<ul> <li>A. Comprehensive ass care plan revision as appropr resident R42 to reflect level of needed for oral cares.</li> <li>B. RNCC revision of Ca appropriate for all residents to current observations/interven</li> </ul>	riate for of assistan are plans a o reflect	ice	

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

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

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

SIND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETED         245512       B. WING       09/06/201         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       900 HILLIGOSS BOULEVARD SOUTHEAST         FIRST CARE LIVING CENTER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D       PREVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETED         F 411       Continued From page 52 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.       F 411       CONTINUED F411-D C. Dental exam declined by resident R42 and his POA. SSD/TREC will review status with resident and family during care plan conferences quarterly.       D. Nursing staff will attempt oral cavity mucosa check on bath day and PRN as resident allows. Primary Physician notified on rounds of refusal of oral checks.	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>		. 0000-0001
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         FIRST CARE LIVING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         (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)       (MSC COMPUL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 411       Continued From page 52 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.       F 411       CONTINUED F411-D C. Dental exam declined by resident R42 and his POA. SSD/TREC will review status with resident and family during care plan conferences quarterly. D. Nursing staff will attempt oral cavity mucosa check on bath day and PRN as resident allows. Primary Physician notified on rounds of refusal of oral checks.				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
900 HILLIGOSS BOULEVARD SOUTHEAST         900 HILLIGOSS BOULEVARD SOUTHEAST         FIRST CARE LIVING CENTER         900 HILLIGOSS BOULEVARD SOUTHEAST         (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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 411         CONTINUED F411-D C. Dental exam declined by resident R42 and his POA. SSD/TREC will review status with resident and family during care plan conferences quarterly.         D. Nursing staff will attempt oral cavity mucosa check on bath day and PRN as resident allows. Primary Physician notified on rounds of refusal of oral checks.	245512		B. WING			09/06/2013		
F 411       Continued From page 52 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.       F 411       CONTINUED F411-D C. Dental exam declined by resident R42 and his POA. SSD/TREC will review status with resident and family during care plan conferences quarterly.       D.       Nursing staff will attempt oral cavity mucosa check on bath day and PRN as resident allows. Primary Physician notified on rounds of refusal of oral checks.					9	00 HILLIGOSS BOULEVARD SOUTHEAST		
routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.C.Dental exam declined by resident R42 and his POA. SSD/TREC will review status with resident and family during care plan conferences quarterly. D.Nursing staff will attempt oral cavity mucosa check on bath day and PRN as resident allows. Primary Physician notified on rounds of refusal of oral checks.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
<ul> <li>by: Based on observation, interview and document review, the facility failed to provide an oral assessment to meet the needs for 1 of 2 residents (R42) in the sample reviewed for dental concerns.</li> <li>Findings include:</li> <li>R42's diagnoses included explosive personality disorder and depression. The quarterly Minimum Data Set (MDS) dated 8/6/13, indicated R42 had moderate cognitive impairment and required extensive assistance with activities of daily living.</li> <li>The annual MDS dated 5/14/13, indicated staff were unable to examine R42's teeth at the time of this assessment.</li> <li>The plan of care dated 2/27/13, indicated R42 was missing several teeth and required limited to extensive assistance with activities of daily living including oral care.</li> <li>The Nutritional Assessment dated 9/4/13, did not identify R42 as having any concerns with eating and did not address the condition of R42's teeth.</li> <li>E. RNCC will complete dental assessment and care plan revisions as appropriate on all residents on admit, quarterly, and with significant changes.</li> <li>F. Education provided to all facility staff on compliance with oral care exams by Mandatory Licensed Staff meeting on October 9, and Mandatory All Staff Meeting on October 10, 2013.</li> <li>G. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation.</li> <li>H. Compliance reported to QAPI meetings quarterly.</li> </ul>	F 411	routine and emerge necessary, assist the appointments; and to and from the der residents with lost of dentist. This REQUIREMEN by: Based on observative review, the facility frassessment to mee residents (R42) in the concerns. Findings include: R42's diagnoses inter- disorder and deprese Data Set (MDS) dater moderate cognitive extensive assistance The annual MDS dater were unable to example this assessment. The Assessment (CAA) concern therefore, of the assessment. The plan of care dater was missing severater extensive assistance including oral care. The Nutritional Association including R42 as havious the severation of the severation of the severation of the severation and the severation of the severation	ency dental services; must if he resident in making by arranging for transportation itist's office; and promptly refer or damaged dentures to a NT is not met as evidenced tion, interview and document ailed to provide an oral et the needs for 1 of 2 he sample reviewed for dental cluded explosive personality ssion. The quarterly Minimum ted 8/6/13, indicated R42 had impairment and required et with activities of daily living. ated 5/14/13, indicated staff mine R42's teeth at the time of he Dental Care Area was not identified as a was not completed at the time ted 2/27/13, indicated R42 I teeth and required limited to e with activities of daily living assment dated 9/4/13, did not ng any concerns with eating	F	411	<ul> <li>C. Dental exam declined by rest R42 and his POA. SSD/TREC will rest status with resident and family during plan conferences quarterly.</li> <li>D. Nursing staff will attempt or a cavity mucosa check on bath day and as resident allows. Primary Physician notified on rounds of refusal of oral che. RNCC will complete dental assessment and care plan revisions a appropriate on all residents on admit, quarterly, and with significant change F. Education provided to all fact staff on compliance with oral care examination of the compliance with oral care examination of the compliance with oral care examination of the completed prior to the completed or an informational package to staff not attes to be completed prior to the completed prior.</li> <li>H. Compliance reported to QAF</li> </ul>	view care d PRN hecks. as s. s. sility ams by eeting ending yee	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		245512	B. WING	i		09	/06/2013
NAME OF	PROVIDER OR SUPPLIER	A		l	TREET ADDRESS, CITY, STATE, ZIP COE		
FIRST C	ARE LIVING CENTER	1			00 HILLIGOSS BOULEVARD SOUTH OSSTON, MN 56542	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	- ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 411	Continued From pa	ge 53	F	411			
	Review of the Use Plan dated 7/16/09 being "ample."	New Admit/ Temporary Care , identified R42's teeth as					
	A Eye and Dental S indicated R42's gua have dental exams	ervices form dated 7/16/09, ardian had not desired R42 to while at the facility.					
	The clinical record did not include any type of comprehensive oral assessment in which the nursing staff may have assessed R42's teeth in order to monitor for changes or possible concerns.			00000000000000000000000000000000000000			
	have multiple darke	o.m. R42 was observed to med areas on his lower teeth hissing from his mouth.					
	by the breakfast tab						
•	R42's guardian had dental services. RN teeth area were usu annual MDS or asse	egistered nurse (RN)-A stated not desired R42 to receive -A explained the residents ially reviewed during the essment period but R42 was most of the MDS evaluation.					
	multiple broken lowe the upper portion of if R42 had upper tee may have complaint bee treated with Tyle	m. RN-A confirmed R42 had er teeth but had not looked at R42's mouth and had no idea eth or not. RN-A stated R42 ts of pain which would have enol. RN-A stated R42 had plaints of pain in the past two					
	67(02-99) Previous Versions (			Facil	ity ID: 00461 If cont	inuation sheet	Page 54 of 6

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 245512 B. WING 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 411 F 411 Continued From page 54 months. RN-A confirmed R42 had not received a comprehensive oral assessment by the nursing staff. On 9/6/13, at 7:08 a.m. R42 stated it had been several years since he had been to the dentist. He stated that some of the back teeth on the lower right side had "uncapped themselves." R42 explained if he had pain, he would tell the nurse about the concerns and that he only had difficulty with hard foods such hard meats. R42 stated the food at the facility was soft enough for him to be able to chew. On 9/6/13, at 10:00 a.m. nursing assistant (NA)-C stated R42 usually refused assistance with oral cares and was unaware if R42 completed the oral cares independently. On 9/6/13, at 11:06 a.m. RN-C stated the facility had not routinely checked resident's oral cavities beyond the MDS assessment. RN-C reviewed R42's record and confirmed the facility had not competed an oral assessment which would indicate any changes in R42's mouth. A policy regarding oral assessments was requested but not provided. 483,65 INFECTION CONTROL, PREVENT F 441 F 441 Α. A written warning and counseling SS∞D SPREAD, LINENS was completed by September 20 for staff members that were involved with infection The facility must establish and maintain an control measures with resident R29. Infection Control Program designed to provide a Β. DON performed audit and check off safe, sanitary and comfortable environment and of skills competency of hand washing to help prevent the development and transmission of disease and infection. practices and wound dressing changes with LPN involved with wound care of resident (a) Infection Control Program R38.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 245512 B. WING 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST FIRST CARE LIVING CENTER FOSSTON, MN 56542 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 55 F 441 F 441 **CONTINUED F441-D** The facility must establish an Infection Control All Licensed Nursing staff educated C. Program under which it on the Mosby's skills for wound care per (1) Investigates, controls, and prevents infections facility policy. in the facility: D. HUC or her designee to perform (2) Decides what procedures, such as isolation, should be applied to an individual resident; and Handwashing audits on 4 staff persons on (3) Maintains a record of incidents and corrective each community weekly x 4 weeks and actions related to infections. monthly thereafter. E. Quarterly report to infection control (b) Preventing Spread of Infection committee. (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control technique was maintained for 1 of 1 resident (R38) observed receiving a pressure ulcer dressing change. In addition, the staff failed to wash their hands after perineal care for 1 of 4 residents (R29) observed receiving perineal care.

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PRINTED: 09/27/2013

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

CENTERS FOR ME	DICARE	& MEDICAID SERVICES			0	<u>MB NO</u>	. 0938-0391
STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1				TE SURVEY APLETED
		245512	B. WING			09/	/06/2013
NAME OF PROVIDER OR	SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST CARE LIVING	CENTER				000 HILLIGOSS BOULEVARD SOUTHEAST COSSTON, MN 56542		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 Continued	From pa	ge 56	F4	41			
Findings in	clude:						
Licensed p to apply gld wash her h LPN-A lifter pillow. R38 with kling. - At 2:48 p. the door wi returned ar the lock in room again cart in the f gloves, was - At 2:49 p. with the sci right malled spot on the a scabbed telfa pad fro area was ol - At 2:51 p. obtained a v blood from then remov bathroom a washing wa - At 2:53 p.r package an on the dress - At 2:54 p.r the room ar hallway. LP across the f	ractical i press LPI ands pri- d R38's i s right for m. LPN- th her gl- d took h R38's nig to get a hallway. I shed her m. LPN- ssor. The blus (ank second area on to preserved. m. LPN- wet wipe between ed her gi nd applied s observed. m. LPN- d applied s observed. n. LPN- d applied s observed.	A went into the bathroom and . LPN-A then wiped dried the 4th and 5th toe. LPN-A loves and went into the ed new gloves. No hand					

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		IMENT OF HEALTH							FORM	: 09/27/2013 APPROVED . 0938-0391
	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATIO	JPPLIER/CLIA						E SURVEY APLETED
			245	512	B. WING				09	/06/2013
	NAME OF F	PROVIDER OR SUPPLIER	<u>Artanının ananının dekeriştiri in ananı</u>				STREET ADDRESS, CITY, STATE,			
	FIRST C	ARE LIVING CENTER					900 HILLIGOSS BOULEVARD S FOSSTON, MN 56542	SOUTHEAST		
	(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	<	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
		Continued From par and then applied gle - At 2:57 p.m. LPN-, the right malleolus v applied the telfa dre - At 2:58 p.m. LPN-, on, touched the doo medication cart into - At 2:59 p.m. LPN-, and laid them on the and checked the tre computer. - At 3:02 p.m. LPN-, kling and applied tag - At 3:05 p.m. LPN-, kling and applied tag - At 3:05 p.m. LPN-, the room - At 3:06 p.m. LPN-, the soiled utility roor hands. - At 3:10 p.m. nursin LPN-A were going to - At 3:10 p.m. nursin LPN-A were going to - At 3:13 p.m. LPN-, that was in the garba up R38s pants. - At 3:15 p.m. LPN-, washed her hands in the faucet handles o she had just washed - At 3:17 p.m. LPN-, soiled utility room. On 9/4/13, at 3:18 p. organized at all for th stated she should ha	oves. A cleansed the with wound clea essing. A left the room or, and then bro- of the room. A then removed e top of the mere- eatment order of A then removed e top of the mere- eatment order of A went into the fir hands and app A wrapped the r pe. A removed her g garbage can net A bagged up the A put the bagge m and did not w hg assistant (NA of check R38 for A went into the fir the bathroom. off with both of he A put the garbage m the bathroom. off with both of he A put the garbage m. LPN-A state he dressing cha ave washed her	with her gloves ught her I her gloves dication cart in the bathroom olied gloves. ight foot with gloves and xt to the bed. e garbage in d garbage in ash her A)-G and incontinence. oathroom and e soiled brief sisted to pull gloves and LPN-A shut her hands that ge bag in the ed she was not inge. LPN-A hands or	F 4.					
F	ORM CMS-256	7(02-99) Previous Versions C	Obsolete	Event ID:53NP11	A	Fac	ility ID: 00461	If continuatio	n sheet F	age 58 of 62

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245512 B. WING 09/06/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 HILLIGOSS BOULEVARD SOUTHEAST **FIRST CARE LIVING CENTER** FOSSTON, MN 56542 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 Continued From page 58 F 441 used hand sanitizer after removing the soiled dressing and applying the new dressing. LPN-A stated there was hand sanitizer in the room she could have used. LPN-A stated normally she would not have left the room that many times. LPN-A stated she had used a scissor from the medication cart for the dressing change, and was unsure if it was clean. LPN-A stated she did not clean the scissor with alcohol prior to using it. On 9/6/13, at 10:36 a.m. the director of nursing stated staff were to wash their hands or use hand sanitizer after removing gloves. The Hand Washing Policy revised 5/04, indicated staff were to decontaminate their hands before having direct contact with patients. Decontaminate hands after having contact with wound dressings. Decontaminate hands after removing gloves. R29 did not receive personal cares with appropriate hand washing on the morning of 9/5/13. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The guarterly Minimum Data Set (MDS) dated 7/9/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living, including extensive assistance with bed mobility and personal hygiene. R29's plan of care (POC) dated 7/17/13, indicated R29 was unable to care for himself with activities of daily living such as bathing, grooming, dressing and transferring. The POC directed the

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PRINTED: 09/27/2013

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

PRINTED: 09/27/2013 FORM APPROVED

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SL IDENTIFICATIO		A. BUILD	0ING			X3) DATE SURVE		
		245	512	B. WING				09/06/201	3	
	ROVIDER OR SUPPLIER				900 H	ET ADDRESS, CITY, STATE HILLIGOSS BOULEVARD STON, MN 56542				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B O THE APPROPRI		) Etion E	
u □ □ □ □ □ □ □ □ □ □ □ □ □	Continued From parstaff to provide assistemembers. On 9/5/13, at 9:00 a R29's room to assist At 9:07 a.m. NA-C R29 with washing h body. NA-A assisted heeded to complete At 9:11 a.m. NA-C and assisted with pro- observed to be inco- small bowel movern or remove the soiled resh incontinent bri- he same gloved has cultain, open the ba- coiled towels in a ba- cultain, open the ba- cultain	a.m. NA-A and N a.m. NA-A and N st with morning of conned gloves is face, hands a d R29 with repose the cares. rolled R29 onto erineal cares. F ntinent of urine tent. NA-C was d gloves prior to ef. Shoes and p and then retures sing. She lef 29's shoes and p il lift sheet under moved R29's w connecting the f assisted to guid the same soiled sling under R29 emoved the glov .m. NA-C confir s on while she curving items in the move and wash liple areas in the	VA-C entered cares. and assisted and upper sitioning as b his right side 329 was and had a s not observed applying a observed with e privacy d place the irrned to R29 t her gloves positioned a r the resident. theelchair and ull body lift to de R29 into gloves on. and walked ves and med she had ompleted he room. I NA-C should ed hands e room.	F	141					
{	he Hand Hygiene p	Obsolete				): 00461	If continuation	I	]	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			O	<b>NR NC</b>	<u>). 0938-0391</u>
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				TE SURVEY MPLETED
		245512	B. WING			09	/06/2013
NAME OF	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ADD LUMID OF LTC			90	00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRSTC	ARE LIVING CENTER			F	OSSTON, MN 56542		
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F 441	Continued From pa	ae 60	F4	41			
	· ·	ange gloves when moving from					
		dy site to a clean body site on					
		The policy also directed the					
		sh their hands after the					
	removal of gloves.						
F 465			F 4	65			
SS=E		L/SANITARY/COMFORTABL			A. All bathroom walls cleaned	and in	
¢u+m	E ENVIRON				good condition September 9, 2013.		
					B. LTC staff monitor environme	ntal	
		ovide a safe, functional,			needs/ cleanliness and fill out a		
		ortable environment for			maintenance report to maintenance/		
	residents, staff and	the public.			housekeepers as needs occur.		ŀ
					C. DON will audit bathrooms we	ekly x	
		IT is not used as sufficienced			4 weeks and randomly thereafter.		
		IT is not met as evidenced			+ weeks and randomly increation.		
	by: Based on observat	ion and interview the facility					
		sident bathroom walls in a					
		condition free from black scuff					
		sident bathrooms and 2 of 28					
		free from gouged, scratched					
	walls.	,					
	Findings include:						
	During the environm	nental tour on 9/6/13, at 9:30					
1 . I		or of environmental services					
	(DES) the following	was observed:					
	Boom #101 had mu	Itiple areas of dark scuff					
	marks on the bathro						
		Itiple areas of dark scuff					
	marks on the bathro						
		Itiple areas of dark scuff					
	marks on the bathro	om walls.					
		tiple areas of dark scuff					
	marks on the bathro	om walls.					
	Room #108 had mul	Itiple areas of dark scuff					
[							

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

Event ID: 53NP11

Facility ID: 00461

If continuation sheet Page 61 of 62

		AND HUMAN SERVICES				INTED: 09/27/2013 FORM APPROVED IB NO. 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	PLE CONSTRUCTION G	6	X3) DATE SURVEY COMPLETED
-		245512	B. WING _	·		09/06/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD SC FOSSTON, MN 56542	UTILAST	
(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 T DEFICIENC'	ON SHOULD B	
	the bed had gouged confirmed the goug have been from pus clean. Room #128 had mu marks on the bathro Room #129 had mu marks on the bathro the bed had gouged the gouge marks ar the area had been r and scratched again The DES verified th approximately 10:00 housekeepers had a they should be using these black marks. to be repaired or fille	bom walls and the wall next to d areas. At this time DES e marks and stated it could shing the bed into the wall to altiple areas of dark scuff bom walls and the wall next to d areas. The EDS confirmed ind stated it appeared some of epaired but had been gouged in before it was ever painted. e findings on 9/16/13, at 0 a.m. and stated access to magic erasers and g them when they notice He added some areas need ed in and then painted. rovide a policy related to to resident rooms or bathrooms.	F 46			sheet Page 62 of 62



October 17, 2013

Lyla Burkman RN Minnesota Department of Health 705 5<sup>th</sup> St. N.W. Suite A Bemidji, MN 56601-2933

Dear Ms. Burkman;

This is to amend the plan of correction submitted on October 11, 2013. The addendum to the plan of correction is as follows:

- **F164 E.** Audits by Dietary Manager to observe the dietary name cards with each new admit and with any diet order changes to ensure residents personal information is kept confidential.
- **F241 G.** North Community nurse & South Community nurse will daily audit meal/snack monitoring forms and will include visual observation at each meal/snack time to ensure all residents are offered nutrition.
- **F 279 L.** R24 is the only current dialysis resident at FCLC. FCLC policy revisions to ensure proper care for the resident undergoing kidney dialysis. Revisions to policy include Fistulas will be checked each shift, what to do in case of emergency or inclement weather, not to take b/ps on arm with fistulas and the incorporation of Sanford dialysis care plan into residents FCLC care plan.

**M.** DON will ensure the care plan of any new dialysis resident follows the FCLC policy and will perform chart audits of all dialysis residents monthly.

- **F 280 F.** RNCC or her designee will audit by visual observation resident R29 oral cares weekly x 4 weeks and randomly thereafter.
- **F 282 H.** Random audits for all other residents will be completed by visual observations weekly x 4 weeks then on a random basis by RNCC's or their designee to ensure ongoing compliance with repositioning, incontinence cares, and ambulation program according to individualized plan of care.
- **F 311 C.** RNCC's or their designee will audit the restorative aide documentation weekly to ensure ambulation programs of all residents have been completed according to individualized plan of care.

T 218.435.1133

EssentiaHealth.org

Fosston
900 Hilligoss Blvd SE
Fosston, MN 56542

B. Visual oral observations of all current residents completed and care plans reviewed F 312 and revised as appropriate according to individual oral hygiene needs. F. RNCC or her designee will audit by visual observations of oral cares weekly x 4 weeks and randomly thereafter for resident R29 G. RNCC or her designee will audit by visual observation incontinence cares weekly x 4 weeks and randomly thereafter for resident R15. H. Random audits by visual observations for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with oral cares and incontinent cares. D. RNCC or her designee will audit repositioning by visual observations and monitoring <u>F 314</u> tool per FCLC policy weekly x 4 weeks then on a random basis to ensure ongoing compliance for residents R29, R38, R15, R55. E. Random audits of all other residents by visual observations and monitoring tool per FCLC policy weekly x 4 weeks and then on a random basis by RNCC or her designee to ensure ongoing compliance with repositioning according to individualized plan of care. B. RNCC or her designee will audit by visual observation incontinence management of F 315 R29, R15, R38, according to their individualized plan of care weekly x 4 weeks then on a random basis thereafter. C. Random audits by visual observation for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with incontinence management and individualized toileting interventions. E. RNCC will follow policy and procedure of FCLC to check incontinent product at time of toileting and changed per manufacturers guidelines. In service training on manufacturers' guidelines for nursing staff by manufacturer representative scheduled on November 6, 2013. I. Eliminate the use of the current Enabler Bars upon arrival of the purchased new LTC F 323 beds. D. Daily review of attendance records by charge nurse to determine if adjustments in F 353 staff need to be made daily to assignment sheets. All available licensed staff will be reassigned to assist with direct resident care. COTA and PTA will assist with restorative nursing duties. Unlicensed personal will assist with housekeeping/bed making. Monetary incentives are offered to staff who pick up additional unscheduled shifts. E. RNCC will complete dental assessment which will include visual observations to F 411 review and revise care plans as appropriate on all residents on admit, quarterly and with significant changes.

**F 465 C.** DON will audit by visual observations bathrooms weekly x 4 weeks and randomly thereafter.

Correction dates for all deficiencies will be November 8, 2013

Feel free to contact me if there are any questions or concerns at (218) 435-7630 and thank you for the opportunity to amend the plan of correction.

Sincerely,

for D. Ait

Kevin Gish Chief Executive Officer

		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG <b>01 - NURSING HOME</b>	ш <sub>а</sub> к		E SURVEY PLETED
			245512	B. WING_			09/0	05/2013
	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
	FIRST C	ARE LIVING CENTER			900 HILLIGOSS BOULEVARD FOSSTON, MN 56542	SOUTHEAST		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD I	BE	(X5) COMPLETIC DATE
	K 000	INITIAL COMMEN	ſS	KO	00			
		FIRE SAFETY		ļ				
		ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.		Porek 18 10-2	3-13		
		ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE IS BEEN ATTAINED IN TH YOUR VERIFICATION.			£		
		Minnesota Departm time of this survey, Main Building was for compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety. At the First Care Living Center 01 ound not in substantial requirements for participation id at 42 CFR, Subpart ty from Fire, and the 2000 cire Protection Association	P				
		Chapter 19 Existing PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY			1 6 2013	Đ	
		Health Care Fire Ins State Fire Marshal I 445 Minnesota Stree St. Paul, MN 55101	pections Division		MIN DEFT. CI		RETY VSII/Y	
		Or by e-mail to:						
LABO	DRATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER BEPRESENTATIVE'S SIGN	ATURE			[	(6) DATE

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

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING 01 - NURSING HOME		(X3) DATE SURVEY COMPLETED
		245512	B. WING	Concerned and the second se		09/05/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY 900 HILLIGOSS BOUL FOSSTON, MN 5654	EVARD SOUTHEAST	
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K 000	Marian.Whitney@s Barbara.Lundberg@ Fax Number 651-2 THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre First Care Living Ce without a basement constructed at 2 diff building was constru-	tate.mn.us and State.mn.us 15-0525 RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: what has been, or will be, done ency. possed, completion date. title of the person ection and monitoring to nce of the deficiency enter is a 1-story building . The building was rerent times. The original ucted in 1972 and was Type II(111) construction. In	K			
	1997, additions to th activates room to th constructed. These construction. The bu	e sleeping rooms and an e north east corner were s additions are Type II(111) uilding is divided into 4 smoke ute and two 2-hour fire				
	automatic fire sprink accordance with NF Installation of Autom edition). The facility smoke detection in t sleeping rooms and accordance with NF	s protected with a complete der system installed in PA 13 The Standard for the patic Sprinkler Systems (1999 has a fire alarm system with he corridor system, in all in common areas, installed in PA 72 "The National Fire edition). The fire alarm				

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

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PRINTED: 09/27/2013 FORM APPROVED

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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER			-	OSSTON, MN 56542		
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K 000 K 011 SS=C	system is monitored notification. Hazard detectors that are o accordance with the (2007 edition). The facility was sum The facility has a ca census of 46 at the The requirement at NOT MET as evider NFPA 101 LIFE SAF If the building has a nonconforming build barrier having at lea rating constructed o addition. Communic corridors and are pro-	d for automatic fire department ous areas have automatic fire n the fire alarm system in Minnesota State Fire Code veyed as one building. pacity of 50 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is need by: ETY CODE STANDARD common wall with a ling, the common wall is a fire st a two-hour fire resistance f materials as required for the cating openings occur only in	К 0		We ordered and installed a new door coordinator for the door next to the ma office on 9/20/13. This door has been tested several times and is meeting compliance. The door will continue to tested each month during the fire drill.	be	
	Based on observation was determined that hour fire barrier door and the other buildin NFPA 101 "The Life (LSC) section 19.1.1 could allow the production from one building to	not met as evidenced by: ons and testing of doors it one of the three sets of 1 1/2 is between the living center gs is not in accordance with Safety Code" 2000 edition .4.1. This deficient practice ucts of combustion to travel another, which will negatively ts, staff and visitors of the					

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

Facility ID: 00461

If continuation sheet Page 3 of 6

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			C	MB NO	. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION 01 - NURSING HOME	(X3) DAT COM	'E SURVEY IPLETED
		245512	B. WING			09/	05/2013
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	1		-	00 HILLIGOSS BOULEVARD SOUTHEAST OSSTON, MN 56542		
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K 011	facility tour on Sept am to 11:30 pm, by the coordinator on the main office, bet hospital did not wor	age 3 esting of doors during the ember 5, 2013, between 9:45 surveyor 03006, revealed that the cross corridor doors near ween the living center and the k properly. The door leafs did by when allowed to become	K	)11			
K 025 SS=F	during the facility to during the exit confi- NFPA 101 LIFE SA Smoke barriers are least a one half hou accordance with 8.3 terminate at an atriu protected by fire-rat panels and steel fra separate compartm floor. Dampers are penetrations of smo	FETY CODE STANDARD constructed to provide at ir fire resistance rating in 3. Smoke barriers may im wall. Windows are ed glazing or by wired glass mes. A minimum of two ents are provided on each not required in duct ike barriers in fully ducted and air conditioning systems.	κo	25	The south smoke barrier penetration sealed using a fire caulking on 9/7/13 Maintenance Department. In the futur barriers will be inspected after each contractor to insure they are sealed a a penetration is made.	by the e the	
	Based on observati one of the two smok accordance with NF Code" 2000 edition deficient practice co combustion to travel	not met as evidenced by: ons it was determined that to barrier walls is not in PA 101 "The Life Safety (LSC) section 19.3.7.3. This uld allow the products of from one smoke other, which will negatively					
RM CMS-256	57(02-99) Previous Versions (	Disclete Event ID:53NP21		Facil	ity ID: 00461 If continue	tion shee	t Page 4 of

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

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

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	T			. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING 01 - NURSING HOME		E SURVEY
		245512	B. WING			05/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 HILLIGOSS BOULEVARD SOUTH FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
<	impact all 50 reside facility. Findings include: Observations during September 5, 2013, pm, by surveyor 030 installed yellow wirh smoke barrier has r wiring sleeve was n The Director of Mali during the facility too during the facility too during the exit confe NFPA 101 LIFE SAF If there is an automa installed in accordar for the Installation of provide complete co building. The syster accordance with NF Inspection, Testing, Water-Based Fire P supervised. There is supply for the system systems are equippe switches, which are building fire alarm sy This STANDARD is	g the facility tour on between 9:45 am to 11:30 206, revealed that the newly ing that penetrates the south not be properly sealed and a ot sealed. Intenance verified this finding ur and with the Administrator erence. FETY CODE STANDARD atic sprinkler system, it is noce with NFPA 13, Standard f Sprinkler Systems, to werage for all portions of the m is properly maintained in PA 25, Standard for the and Maintenance of rotection Systems. It is fully s a reliable, adequate water n. Required sprinkler ed with water flow and tamper electrically connected to the rotem. 19.3.5	KO		Fire on	

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

Facility ID: 00461

If continuation sheet Page 5 of 6

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

PRINTED: 09/27/2013 FORM APPROVED OMB NO, 0938-0391

T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SUI COMPLET	
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PROVIDER OR SUPPLIER ARE LIVING CENTER	r	90	D HILLIGOSS BOULEVARD SOUTHEAST		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE CO	(X5) MPLETIO DATE
NFPA 101 "The Life (LSC) section 19.3. allow the a fire to pr all 50 the residents, facility. Findings include: Observations during September 5, 2013, pm, by surveyor 030 entrance vestibule is The Director of Main during the facility too	Safety Code" 2000 edition 5. This deficient practice could ogress cutting of escape for staff and visitors of the the facility tour on between 9:45 am to 11:30 006, revealed that the south s not sprinkler protected. Intenance verified this finding ar and with the Administrator	K 056			
	PROVIDER OR SUPPLIER ARE LIVING CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa NFPA 101 "The Life (LSC) section 19.3. allow the a fire to pr all 50 the residents, facility. Findings include: Observations during September 5, 2013, pm, by surveyor 030 entrance vestibule is The Director of Main during the facility too	DF CORRECTION       IDENTIFICATION NUMBER:         245512         PROVIDER OR SUPPLIER         ARE LIVING CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 5         NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow the a fire to progress cutting of escape for all 50 the residents, staff and visitors of the facility.	DF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 0         245512       B. WING         PROVIDER OR SUPPLIER       ST         ARE LIVING CENTER       90         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 5       K 056         NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow the a fire to progress cutting of escape for all 50 the residents, staff and visitors of the facility.       K 056         Findings include:       Observations during the facility tour on September 5, 2013, between 9:45 am to 11:30 pm, by surveyor 03006, revealed that the south entrance vestibule is not sprinkler protected.       The Director of Maintenance verified this finding during the facility tour and with the Administrator	DF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - NURSING HOME         245512       B. WING	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING 01 - NURSING HOME       COMPLET         245512       B. WING       09/05/2         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       900 HILLIGOSS BOULEVARD SOUTHEAST         ARE LIVING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       900 HILLIGOSS BOULEVARD SOUTHEAST         FOSSTON, MN 56542       FOSSTON, MN 56542       COMPLET         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         Continued From page 5       NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow the a fire to progress cutting of escape for all 50 the residents, staff and visitors of the facility.       K 056         Findings include: Observations during the facility tour on September 5, 2013, between 9:45 am to 11:30 pm, by surveyor 03006, revealed that the south entrance vestibule is not sprinkler protected.       He Director of Maintenance verified this finding during the facility tour and with the Administrator       He Director of Maintenance verified this finding

If continuation sheet Page 6 of 6

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Facility ID: 00461



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 3108

September 27, 2013

Mr. Kevin Gish, Administrator First Care Living Center 900 Hilligoss Boulevard Southeast Fosston, Minnesota 56542

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5512023

Dear Mr. Gish:

The above facility was surveyed on September 3, 2013 through September 6, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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.

First Care Living Center September 27, 2013 Page 2

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

Lyla Burkman, Unit Supervisor Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, Minnesota 56601

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Are Klegepe

Anne Kleppe, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (612) 201-4124 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00461	B. WING		09/0	6/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the 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 contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	a rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	this Department's s and the following lic When corrections a date, make a copy original to the Minn	TS: , 5, and 6, 2013, surveyors of taff, visited the above provider censing orders were issued. are completed, please sign and of these orders and return the esota Department of Health, nce Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

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

TITLE

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/0	6/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	ARE LIVING CENTER		IGOSS BOU N, MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	Certification Progra Bemidji, MN 56601	m; 705 5th St. N.W., Suite A, -2933		The assigned tag number a far left column entitled "ID F The state statute/rule numb corresponding text of the sta out of compliance is listed ir "Summary Statement of De column and replaces the "To portion of the correction ord column also includes the fi are in violation of the state s statement, "This Rule is not evidenced by." Following th findings are the Suggested Correction and the Time Pe Correction.	Prefix Tag." er and the ate statute/rule the ficiencies" o Comply" er. This ndings which statute after the met as ne surveyors Method of	
				PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH P	HICH AN OF LIES TO ONLY. THIS	
				THERE IS NO REQUIREMI SUBMIT A PLAN OF CORR VIOLATIONS OF MINNES STATUTES/RULES.	ECTION FOR	
2 555	MN Rule 4658.0409 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555			
	must develop a con each resident within completion of the co assessment as defi comprehensive plan	elopment. A nursing home nprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		900 HILL	IGOSS BOULI	EVARD SOUTHEAST		
FIRST	ARE LIVING CENTER	FOSSTO	N, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 2	2 555			
	responsibility for th appropriate staff in the resident's need practicable, with the	n, a registered nurse with e resident, and other disciplines as determined by ls, and, to the extent e participation of the resident, guardian or chosen				
	by: Based on observat review, the facility f comprehensive pla resident (R24) to in dialysis access por to develop a POC t interventions for re	n of care (POC) for 1 of 1 include the monitoring of a t. In addition, the facility failed				
	Findings include:					
	R24 lacked a comp monitoring of a dia	prehensive POC to address the lysis access port.	;			
	and end stage rena Minimum Data Set R24 had no cogniti	d with diabetes, heart disease al failure. The quarterly (MDS) dated 6/4/13, indicated ve deficits and was nsfers, ambulation and mobility				
	dialysis three times renal disease. The renal diet and was and directed staff to intake weekly, prov	6/12/13, indicated R24 had a week due to end stage POC indicated R24 received a on 1000 - 1500 fluid restriction o monitor weight and oral ride sufficient fluids thru meals				
	POC also indicated could be given via	so to provide education. The I no medications or solutions the dialysis access port unless ologist and lab draws should				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONEACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEEGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 555	Continued From pa	age 3	2 555			
	port. The POC dire blood pressure priot to direct staff not to failed to identify wh monitoring the site was to be monitore place if the access The facility's North Home Plan of Care developed and sup which directed staff pressure on the ex access. This plan of protection of a pati- health and well-bei directed facility stat the extremity access feeling for a pulsati a bruit via stethosc assessing for redu- infection. The plan dressing and band hours following dia and if staff were un directed them to non nephrologist for fur On 9/6/13, 8:20 a.r on the bed removin access site. R24 st bleeding or signs of also stated the num- the access site and about it.	extremity containing a dialysis acted staff to monitor R24's or to dialysis, however, it failed o take the blood pressure on dialysis site was. The POC also no was responsible for or how often the access site ed or what interventions were in site started to bleed. nurse's station had a Nursing e for Hemodialysis Patients oplied by R24's dialysis provide f to never to take blood tremity that contains a dialysis of care also noted the ents access was critical to thei ng on hemodialysis and ff to perform a daily check of ss. This daily check included ion in the access, listening for ope in the access and ess, warmth or signs of of care indicated the access ages may be removed with 6-8 lysis and if there was bleeding hable to stop the bleeding, otify the dialysis unit or ther instructions. m. R24 was observed seated ng the dressing from the tated she would report any f infections to the nurse. R24 ses had not routinely checked d sometimes would ask her ask a.m. registered nurse (RN)-B	r r			

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 555	Continued From pa	ge 4	2 555			
	the nurses did not of stated when the site something in the el- administration reco now they don't have blood pressures we of the access site a interventions relate directing staff which on.	e returned from dialysis and do anything to the site. RN-B e was new there was ectronic medication rd (e-mar) to do / sign off, but e to do anything. RN-B stated ere not to be taken in the arm and verified the POC lacked d to monitoring the site or n arm to take blood pressure a.m. the licensed practical				
	nurse (LPN) and wa the POC but stated stated there used to	ard clerk verified it was not on it could be added. The LPN be an order in the e-mar to ite daily but for some reason it				
	Nursing Home Plar	the facility provided was the of Care for Hemodialysis by the dialysis provider.				
	risk for the develop identified intervention mattresses on the to the POC did not dir	B/13/13, indicated R15 was at ment of pressure ulcers and ons such as pressure reducing bed and wheelchair. However, ect the staff as to the R15 was to be repositioned.				
	main lobby, seated body mechanical lif R15 was assisted to breakfast. At 8:24 dining room and do lobby. While in the asleep while in the assistance. At no ti	.m. R15 was observed in the in a wheelchair with a full t sling under him. At 7:50 a.m. o the dining room for a.m. R15 wheeled out of the wn the hallway to the main lobby R15 was observed to fall wheelchair without receiving me was R15 observed to be imself in the wheelchair. At				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 5	2 555			
	staff members had around 6:30 a.m. been repositioned NA-A then assisted mechanical lift. R1 be equipped with a cushion. R15's skir intact free of press	assistant (NA)-C stated other assisted R15 out of bed She confirmed R15 had not since that time. NA-C and d R15 to bed via a full body 5's wheelchair was observed to pressure redistribution n was observed to be pink and ure ulcers. C confirmed R15 had not				
	6:30 am. and 10:33 minutes.	e with repositioning between 3 p.m. a total of 4 hours and 3				
	stated R15 was to repositioning every	5 p.m. registered nurse (RN)-A receive assistance with v two hours and stated the POC revised to direct the staff sitioning schedule.				
	ulcers (PU), arteria	ncluded a history of pressure al disease and peripheral PVD), a circulatory problem.				
	was at risk for the	DS indicated she had PU's and further development of PU's taff extensive assistance for mobility.				
	was at risk for pres to assist with repos (pressure relief) ev however, the POC	dated 8/28/13, indicated R38 soure ulcers and directed staff sitioning and offloading very hour during awake hours, lacked indication of the s to be turned and repositioned				
		s observed continuously in bec 7:05 a.m. until 10:15 a.m.	ł			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IRST C	ARE LIVING CENTER	2	LIGOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 6	2 555			
	her back at 7:00 a. turned in bed every turned to her left si and 15 min without At 1:02 p.m. RN-A PU's. RN-A stated every 2 hours while	verified R38 was at risk for R38 was to be repositioned e in bed. RN-A verified the dule for R38 while in bed was				
		policy revised on 1/2009, velop a comprehensive care ent.				
	The Director of Nu for the licensed sta developing individu care. The Director	THOD FOR CORRECTION: rsing could provide education off regarding the importance of alized plans related to residen of Nursing could randomly for the effectiveness of the				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	9			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care Il personnel involved in the t.				

Minnesc	ota Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00461	B. WING		09/0	6/2013
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EIRST C	ARE LIVING CENTER	900 HILLI	GOSS BOUL	EVARD SOUTHEAST		
		FOSSTON	I, MN 56542			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 CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 7	2 565			
Minnesota D	by: Based on observat review, the facility f accordance with th care (POC) for 1 or observed for perine provide ambulation POC for 1 of 1 resi ambulation; the fac incontinence care a residents (R38, R2 incontinence care, provide repositionin of 5 residents (R38 at risk for pressure Findings include: INCONTINENCE C R38 was admitted ulcer on her ankle arterial disease and (PVD) a circulatory R38's The current staff to check R38' hours during the da On 9/5/13, from 7:0 was continuously of bed. At 10:09 a.m. nursi	CARE on 9/12/12, with a pressure and upper back. R38 also had d peripheral vascular disease problem. POC dated 7/3/13, directed s incontinent product every 2-3 ay. 05 a.m. until 10:09 a.m. R38 bserved asleep on her back, in ing assistant (NA)-A and NA-C n. Both verified there were				

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010
FIRST C	ARE LIVING CENTER		IGOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 8	2 565			
	At 10:15 a.m. NA-C stated R38s brief was changed at 7 a.m. and R38 was incontinent of urine at that time. NA-C stated R38's brief was to be changed every 2 hours.					
		C changed R38's brief which e very wet. (3 hours and 20 st brief change).				
	incontinent product	ered nurse (RN)-A stated R38's was to be changed every 2-3 ay. RN-A verified the POC was				
	REPOSITIONING					
	risk for PU's. RN-A	o.m. RN-A verified R38 was at stated R38 was to be nen up in the wheelchair.				
		36 a.m. until 10:53 a.m. R38 bserved seated in her				
	the wheelchair at 8 NA-A were the prim verified R38 had no was assisted into th	8 stated R38 was assisted into 20 a.m. NA-B stated her and hary NAs for R38. NA-B ot been repositioned since she he wheelchair. NA-B confirmed ositioned every hour when in				
		and NA-B were observed to . (2 hours and 35 minutes g).				
	R55 was not repos POC.	itioned as directed by the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 9	2 565			
	history of pressure	I/10/13, indicated R55 had a ulcers and directed staff to ositioning every two hours and				
	observed seated in assistance with rep and NA-C was obs a full body mechan observed to be equ redistribution cushi	05 a.m. to 9:50 a.m. R55 was her wheelchair without positioning. At 9:50 a.m. NA-A erved to assist R55 to bed via ical lift. R55's wheelchair was hipped with a pressure on. A skin protective dressing e intact over the left hip.				
	had been assisted had not received as	a.m. NA-A confirmed R55 out of bed at 7:00 a.m. and ssistance with repositioning total of 2 hours and 50 minutes				
	risk for the develop	p.m. RN-A stated R55 was at ment of pressure sores and every two hours as the POC				
	Perineal and Incon	tinence cares:				
	incontinence cares	assistance with perineal or as the POC directed for s on the morning of 9/5/13.				
	total assistance of	8/13/13, indicated R15 required 1-2 staff for perineal cares and ovide incontinence cares every				
	in a wheelchair. At to the dining room	u.m. R15 was observed seated 7:50 a.m. R15 was assisted for breakfast. At 8:24 a.m. f the dining room and down the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 HE APPROPRIATE	(X5) COMPLET DATE
2 565	fall asleep in the w lobby and without a.m. NA-C stated of assisted R15 out of confirmed R15 had incontinence caress NA-A then assisted mechanical lift. R1 an incontinence pro- urine. NA-A remova applied a fresh brie observed to receive cares. At 10:40 a.m. NA- received assistance between 6:30 am. hours and 3 minute R15 had not receive an incontinent epis On 9/5/14, at 12:35 received incontinent and perineal caress as directed by the Ambulation: R13's POC dated 8 assist R13 to a sta four prong cane to 40 feet or more 2-	<ul> <li>n lobby. R15 was observed to heelchair while in the main receiving assistance. At 10:33 other staff members had if bed around 6:30 a.m. She d not been assisted with a since that time. NA-C and d R15 to bed via a full body 15 was observed to be wearing oduct which was saturated with yed the saturated brief and ef. At no time was R15 e assistance with perineal</li> <li>C confirmed R15 had not e with incontinence cares and 10:33 p.m. a total of 4 es. In addition NA-C confirmed red perineal cares after having ode.</li> <li>5 p.m. RN-A stated R15 was to note cares every two hours, after each incontinent episode POC.</li> <li>B/28/13, directed two staff to nding position and to use a assist R13 to ambulate up to 3 times per week.</li> </ul>	2 565	DEFICIENCY	<u>n</u>	
	walk all of the time because he require	p.m. R13 stated he used to , but had not walked as much ed assistance with ambulation.				
	following information					

53NP11

If continuation sheet 11 of 67

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/	06/2013
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	09/	50/2013
		900 HILL		EVARD SOUTHEAST		
IRST CA	ARE LIVING CENTER	FOSSTO	N, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 11	2 565			
	times with distance feet. The week of 6/15/1 feet two times. The week of 6/22/1 feet on one occasio The week of 6/29/1 feet on one occasio The week of 7/6/13 feet on one occasio The week of 7/13/1 ambulate. The week of 7/20/1 ambulate. The week of 7/20/1 ambulate. The week of 7/27/1 feet on once occas The week of 7/27/1 feet on once occas The week of 8/4/13 times with distance feet. the week of 8/11/13 feet one time. The week of 8/18/1 100 feet one time. The week of 8/25/1 times with distance feet. The week of 9/1/13 times with distance feet. On 9/6/13, at 8:10 a ambulate with resto (RNA)-A and NA-C (LPN)-C following v able to ambulate 10	<ul> <li>3- 7/5/13, R13 ambulated 25 on.</li> <li>- 7/12/13, R13 ambulated 15 on.</li> <li>3 - 7/19/13, R13 did not</li> <li>3 - 7/26/13, R13 did not</li> <li>3 - 7/26/13, R13 did not</li> <li>3 - 8/3/13, R13 ambulated 35 ion.</li> <li>- 8/10/13, R13 ambulated 3 s varying from 10 feet to 100</li> <li>8- 8/17/13, R13 ambulated 13</li> <li>3 - 8/24/13, R13 ambulated 13</li> <li>3 - 8/24/13, R13 ambulated 3 s varying from 50 feet to 200</li> <li>- 9/6/13, R13 ambulated 3 varying from 55 feet to 125</li> <li>a.m. R13 was observed to orative nursing assistant with licensed practical nurse vith the wheelchair. R13 was 00 feet with assistance.</li> </ul>				
	had not consistently	a.m. RN-C confirmed R13 y received assistance to				
nesota De ATE FORM	epartment of Health M		<sup>6899</sup> 53	3NP11	If continuati	on sheet 12 c

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/	06/2013
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IRST C	ARE LIVING CENTER	2	LIGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 12	2 565			
	ambulate as the Po	OC directed.				
	Incontinence cares	and repositioning:				
	incontinence cares	e timely assistance with and repositioning on the as directed by the POC.				
		7/17/13, directed staff to assist cares and repositioning every				
	on his back. R29 w back until 9:10 a.m were observed to p	a.m. R29 was observed in beavas observed to remain on his a. at which time NA-A and NA-Corovide R29 with morning served to be incontinent of skin.				
	been last assisted	a.m. NA-C stated R29 had with incontinence cares at 6:00 urs and ten minutes earlier.	D			
	receive assistance	p.m. RN-A stated R29 was to with incontinence cares and two hours as directed by the				
	directed staff to fol	policy revised on 1/09, low the plan of care to ensure ent, staff members and facility.				
	The director of nur a system to educate	THOD FOR CORRECTION: sing or designee could develop te staff and develop a to ensure staff are providing	D			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/	06/2013
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	care as directed by Quality Assessmen	ge 13 the written plan of care. The t and Assurance (QAA) o random audits to ensure	2 565			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 590	MN Rule 4658.0435 Subp. 1 Confidentiality of Clinical Records and Info		2 590			
	Information in the c form or storage me confidential accordi chapter 13 and sec and federal regulati information in a nur considered confide available to all pers are responsible for clinical information representatives of t	ning confidentiality of records. linical records, regardless of thods, must be kept ng to Minnesota Statutes, tions 144.335 and 144.651, ons. A resident's clinical sing home must be ntial but it must be made ons in the nursing home who the care of the resident. The must be open to inspection by he Department of Health and rized to obtain access.				
	by: Based on observati review, the facility fa information was not 23 residents (R50, R68, R59, R37, R3 R55, R11, R42, R3, the South dining roo R40, R41, R58, R5	ent is not met as evidenced on, interview and document ailed to ensure private dietary t accessible to the public for R19, R13, R29, R26, R33, 8, R56, R34, R66, R15, R27, , R1, R51, R43, R20, R67) in om and for 24 residents (R24, , R21, R69, R65, R46, R6, 6, R48, R36, R39, R8, R2,				

Minneso	ta Department of He	alth			-	_
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00461	B. WING		09/0	6/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(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
2 590	Continued From pa	ge 14	2 590			
	R70, R45, R23, R5	2) in the North dining room.				
	Findings include:					
	done in the the Sou were observed sea dietary cards on a s resident. The dietar first and last name	b.m. a dining observation was th dining room. Residents' ted at the tables, with yellow stand placed in front of each ry card included the resident's and their diet according to the 'his information was visible to be dining room.				
	The South dining ro	oom dietary cards read:				
	liquids at breakfast, R19, R13, R33, R1 and R67 all had reg R29-mechanical so R26-mechanical so have nectar liquids a meal. R68 and R59 both R37 and R27 both R37 and R27 both regular liquids. R38-regular diet, sr R56-regular low so R34-mechanical so regular liquids. R66-regular diet, no R55-mechanical so	ft diet with nectar thick liquids. ft diet with thin liquids, may if coughing more than 3 spells had regular low sodium diets. had mechanical soft diets with nall portions. dium, low fat diet. ft food, ground meat and				
Ainneeds D	done in the the Sou yellow dietary cards	a.m. a dining observation was th dining room. The same s which displayed personal n were observed on a stand ach resident.				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 590	Continued From pa	ge 15	2 590			
	On 9/5/13, at 7:57 a.m. a dining observation was done in the the South dining room. There same yellow dietary cards were observed on a stand placed in front of each resident.					
	manager (NSM), ve included the reside stated there was a cupboard that ident She stated staff co cupboard for the in she had been spea	p.m. the nutrition services erified the dietary cards nts' diet order. The NSM list in the dining room ified the residents' diet order. buld just look inside the formation. The NSM stated king with registered nurse				
	questioned whethe NSM also verified t dining room were a with their name and					
	The North dining room dietary cards read:					
	R16, R45, and R52	, R36, R48, R2, R70, R67, all had regular diets potassium, 1400 ml fluid				
	R40-ground meat t					
	R5-regular diet with R21-mechanical so R65-low fat, low so	n small portions. ft diet with ground meat. dium diet.				
	liquids.	diet. free diet with honey thick rbohydrates, no concentrated				
	sweets diet. R8-pureed diet with R23-regular low so	n regular liquids.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			-			
		00461	B. WING		09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
FIRST C	ARE LIVING CENTER	2	N, MN 56542	EVARD SOUTHEAST		
(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 HE APPROPRIATE	(X5) COMPLET DATE
2 590	Continued From pa	age 16	2 590			
	dated 4/03, indicate copy of the Privacy their protected hea The policy further in	TICE POLICY & PROCEDURE ed residents would receive a Notice that would explain how Ith information would be used. ndicated employees, staff and n access the resident's	1			
	The nutrition servic resident dietary info cards. The Quality	THOD FOR CORRECTION: ces manager could remove ormation from the dietary Assessment and Assurance could do random audits to e.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	9			
2 800	MN Rule 4658.051 Staffing requirement	0 Subp. 1 Nursing Personnel; nts	2 800			
	home must have o number of qualified registered nurses, nursing assistants residents at all nurs in all buildings if mo	g requirements. A nursing n duty at all times a sufficient d nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.				
	by: Based on observat failed to ensure sul	ent is not met as evidenced ion and interview, the facility fficient qualified nursing staff neet the residents' needs for				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING		09/	09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 17	2 800				
	resident's physical, well-being, thus en	nanner which promoted each mental and psychosocial hancing their quality of life. he potential to affect all 47 n the facility.					
	Findings include:						
	9/6/13, staff were c consistently provide directed by their pla	conducted on 9/3/13 thru observed to not be able to e services for the residents as ans of care based on a sessment of their needs.					
	manner which pron	o provide timely meals in a noted dignity for 3 of 3 9, R15) in the sample who did ast. See F241.					
	according to the as	p provide ambulation services sessed need for 1 of 1 e sample. See F311.					
	cares for 1 of 1 res were dependent or addition, the facility	o provide assistance with oral ident (R29) in the sample who a staff for oral hygiene. In a failed to provide perineal care (R15) reviewed for See F312.					
	risk for pressure ul repositioning for 4	o ensure a resident identified a cers (PU) received timely of 5 residents (R38, R15, R55 mple identified at risk for ee F314.	t				
	risk for urinary inco assistance for 3 of	o ensure residents identified at ontinence received timely 4 residents (R38, R15 and e identified as incontinent					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING	B. WING		09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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	
2 800	Continued From pa	age 18	2 800				
	based on the comp F315.	based on the comprehensive assessment. See F315.					
	five weeks. (8/1/13 two weeks (9/6/13 pattern determined nursing assistants work as NA and as to complete restora designated to assis licensed nurses rou administration, doo non-direct care nur to assist NAs with the necessary.	re reviewed for the previous 3 - 9/6/13) and the projected - 9/22/13). The facility staffing I the day shift required two (NA), two nursing assistants to a universal workers, two NAs ative exercises and one NA st residents with baths. Two utinely did medication cumentation, and other rsing duties, but were available the care of residents if deemed staffing pattern consisted of five	1				
	NAs to work an eig	ift along with two licensed	2				
	The night shift const two NA's.	sisted of one licensed staff and	ł				
	days of which 12 d and 20 days (8/1, 2 22, 23, 25, 26, 27, staff had shortages September from 9/ daily staffing shorta projected nursing s the facility had six of	for August 2013, identified 31 ays were without shortages 2, 3, 4, 5, 7, 8, 9, 11, 16, 17, 20 29, 30, 31) nursing assistant s of 1 - 3 staff members. In (1/13 - 9/6/13, the facility had ages of 1-3 staff. Of the schedule from $9/7/13 - 9/22/13$ , days (9/9, 12, 14, 15, 17, 18) in staff were to work with 1 -2 short.					
	resident, reported t	p.m. R59 an alert and oriented the facility was frequently short ing. R59 explained he would					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING	B. WING		06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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
2 800	Continued From pa	age 19	2 800			
		nd 6:30 a.m. but the facility did enough staff to help him.				
	resident stated it to	p.m. R47, an alert and oriented ook a long time for the staff to e morning, but felt that was par g home.				
	with five nursing as two medication nur the facility, licensed assisted in the dinin (RN)-A, LPN-D/sod director of nurses (	a.m. the facility was staffed ssistants instead of seven and ses. As support staff arrived at d practical nurse (LPN)-A ng room. Registered nurse stal service designee, and the DON) were not observed to o were providing direct care.	t			
	facility was short a running behind. Sh such as the registe the licensed practic as the social servic and the director of they did not check see how things wer may check in with t assists with the din routinely assist with NA-C stated the fac staffed. NA-C adde residents assigned cares to. Of those a residents required a	A p.m. NA-C stated she the nursing assistant and she was e stated when the support staf ered nurses doing paper work, cal nurses (LPN) who worked e designee and the ward clerk nurses arrived at the facility, in with the staff on the floor to re going. NA-C stated they the wing nurses and LPN-A ing room, but they do not n providing cares on the floor. cility was frequently short ed she and NA-A had 22 to them to provide morning 22 residents,13 of the assistance of two staff for norning cares and only two npletely independent with their	f			
		p.m. NA-A stated the facility ffed for the past few weeks.				

	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING		09/	09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		GOSS BOULE I, MN 56542	EVARD SOUTHEAST			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			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	HE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	ige 20	2 800				
		ng staff will help when they consistently ask if the NA's on					
	morning she assist dining room and wi had a chance. She a.m. that the staff o	p.m. LPN-A stated each s the residents in the north Il help the staff whenever she stated she was aware at 7:30 on the floor were two nursing it she was unable to help due					
	arrived at the facilit made aware the fac stated on a regular about such concerr morning report. She the staff on the floo assist. She stated s morning of 9/5/13, I stated the facility ha patterns and the ch	p.m. RN-A stated she had y at 8:40 a.m. and had been cility was two NA's short. She day she would be informed hs around 10:00 a.m. during e stated she could easily help or but had not been asked to she was unable to assist the because of a meeting. She ad occasional short staffing harge nurses called as many to try to find assistance to					
	the south cart state NAs on the floor as LPN-A usually help	o.m. LPN-C who was working the LPN's try to help the much as possible. She stated ed with meals, but the other insistently help unless asked.					
	who requested to re facility was short st staff member expla facility had 17 shifts death, one planned	o.m. a nursing staff member emain anonymous stated the affed quite frequently. The lined that in the past week, the s which were not filled, one I discharge and five new aff member stated the support					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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
2 800	Continued From pa	age 21	2 800			
		n with the charge nurses, but vith cares. The staff stated t with meals.				
	On 9/6/13, at 7:16 a.m. NA-A stated the facility had four NA's, a bath aide and a float (total of six). The facility was short one nursing assistant.					
	stated she ended u nursing assistant 2 direct care for the r not consistently abl	a.m. restorative aide (RA)-A up working the floor as a -3 days a week to provide residents. She stated she was le to complete restorative providing direct care support.				
	8:25 a.m. the DON and LPN-A reviewed stated the facility w difficult transition do some staffing chan the DON did not lea When questioned a short, the DON did based on the statis still meeting the ne questioned if the cu cares, she stated s concerns. The DOI days, the facility ha death and four new the staffing pattern	with the DON on 9/6/13, at explained each morning she ed the staffing patterns. She ras currently going through a ue to employee illness and ges. She explained LPN-A and ave the facility "short short." as to the definition of short not respond. She explained tical findings, the facility was eds of the residents. When urrent residents were receiving he was unaware of any N confirmed in the past seven id one planned discharge, one v admissions. Upon review of , the DON confirmed the rently meeting the established				
	assisted the staff o assisted with filling of the staff assist w	a.m. LPN-D stated she n the floor when possible and the open shifts. She stated all vith picking up shift and atistical findings, the facility				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 22	2 800			
	was meeting the re	equired staffing ratios.				
	A policy regarding s but not provided.	sufficient staff was requested,				
	The director of nurs for all staff to ensur and their needs are could revise the wo accommodate each Quality Assessmen	THOD FOR CORRECTION: sing could provide education re that residents receive care e met. The director of nursing orkloads of staff to h resident's needs. The and Assurance (QAA) or random audits to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on d preferences as identified in e resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.	1 t			
	This MN Requirem	ent is not met as evidenced				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(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 T DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	review, the facility the was safe to use for the sample. In add ensure enabler bar safety which had the residents (R38, R4	tion, interview and document failed to ensure an enabler bar r 2 of 2 residents (R38, R42) in ition, the facility failed to rs were assessed for resident ne potential to affect 17 2, R37, R56, R33, R20, R59, 23, R58, R44, R57, R6, R52, nabler bars.				
	Findings include:					
		d with arterial disease and r disease (PVD, a circulatory				
	6/25/13, indicated	num Data Set (MDS) dated R38 was cognitively intact and assistance of two staff for bed ers.				
		(POC) dated 7/3/13, indicated bars on the bed to increase he				
	were observed on rail a horizontal PV made from plastic ran left to right on t screws on the end sharp to the touch.	a.m. bilateral enabler bars R38's bed. In the center of the C pipe (a combination pipe and vinyl) was observed which the bar. The PVC pipe had 2 of the enabler bar that were R38 stated the rails were couple of times she had the rails.				
	assistant (NA) obs upper arm covered	nt report indicated a nursing erved a skin tear on R38s right I with dried blood. After oted there were three separate				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING		09/	09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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) COMPLETI DATE	
2 830	tears in a row with which measured 1.	age 24 the one closest to the elbow 0 centimeter (cm), next 0.5 cm e was a "V"-shaped tear	2 830				
	measuring 0.75 cm On 8/9/13, the nurs NA had observed a outer arm. Had drie difficult to cleanse a The note indicated this had occurred a bumped her arm of previous night. The	n on each side of the "V." sing progress notes indicated a a skin tear on R38's upper ed blood over the area and was adequately due to fragile skin. the NA had asked R38 how and the resident stated she had n her enabler bar during the e note also indicated there a line. This was documented	6				
	incident report was stated the entry for stamped on the co	a.m. LPN-B verified the 8/9/13, undated when printed. LPN-B the incident report was date mputer. LPN-B then printed nursing progress note.					
	(DON), stated she tears were from the LPN-D had not doo the skin tears were stated she would h	a.m. the director of nursing had not realized R38's skin e enabler bar. The DON stated cumented on the incident repor from the enabler bar and ave had to read the nurses as from the enabler bar.					
	designee (SSD) sta after the incident a	2 a.m. the social service ated she had spoken with R38 nd R38 had told the SSD she on the enabler bar .					
	disorder and depre dated 8/6/13, indica cognitive impairme	cluded explosive personality ssion. The quarterly MDS ated R42 had moderate nt and required extensive ivities of daily living including					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		00/2010
IRST C	ARE LIVING CENTER	900 HILL		EVARD SOUTHEAST		
(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 ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 25 Pressure Ulcer Care Area	2 830			
	Assessment (CAA) utilized enable bars and repositioning. was was able to tu	) dated 5/22/13, indicated R42 s on the bed to assist in turning The CAA also indicated R42 rn from side to side in the bed required extensive assistance				
	bilateral enable ba	2/27/13, indicated R42 utilized rs to aid with turning bed mobility and to aide in				
	identified R42 as h The reason for the were placed was n form stated the bar	vice form dated 4/26/13, aving enabler bars in place. bars and the date which they ot identified on the form. The rs were in place prior to the the Alternative Device form on 4/26/13.				
	to be equipped with bars. The bars wer adapted with one F right on the bar. T created between th large. The edges o with screws which the edges of the pi	p.m. R42's bed was observed in two large "U" shaped enabler the observed to have been PVC pipe that ran from left to the space which the PVC pipe the pipe and the bed frame was if the pipe were held in place were sharp to the touch and pe were not secure to the inner sing it to move up and down, ges of the pipe.				
	maintenance depa enabler bars to ens resident use. RN-A used his bars for b	p.m. RN-A stated the rtment had visualized the sure appropriate size for a stated she was aware R42 ed mobility, but at no time did e assessments on the bars to				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOULE I, MN 56542	EVARD SOUTHEAST		
(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
2 830	ensure they were s p.m. RN-A measure PVC pipe and the b space was greater the tape around the bar was peeling aw edges of the PVC p could potentially be The Federal Food a Hospital Bed Syste Assessment guidar dated 3/10/06, indic bed rails was not to On 9/6/13, at 9:20 a member (MS)-A sta facility, the enabler bars with no addition the space between facility staff member to each of the rails the rails did not exc he was unaware wh PVC pipe. He state pipes. On 9/6/13, at 9:30 a environmental serv had purchased sev ago. The DES state more rails over the maintenance staff h He explained the P all of the rails to de- entrapment. He state PVC pipe should has should all be equipp	afe for the residents. At 2:30 ad the spaces between the bed frame. RN-C reported the than 8.0 inches. RN-C verified a main U shape on the right ay and that the screws and bipe were rough and residents come injured. and Drug Administration (FDA) m Dimensional and nee to Reduce Entrapment cated the space between the exceed 4 3/4 inches. a.m. maintenance staff ated when ordered by the bars were large U shaped nal bars in them to decrease the rails. He explained the rs had added two PVC pipes to ensure the space between beed 4 3/4 inches. He stated by R42's rails only had one d it should have two PVC	2 830	DEFICIENC	τ)	

STATEME	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00461	B. WING		09/	09/06/2013	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
IRST C	ARE LIVING CENTER		GOSS BOULI I, MN 56542	EVARD SOUTHEAST			
(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 TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	of the original manualtered in an attemp added the facility w reviewing new bed with enabler bars a for them. However, house and alternati available. On 9/6/13, at 12:00 (LPN)-A provided a currently had 17 rese enabler bars which the manufacturer's by staff. The list inco R33, R20, R59, R1 R57, R6, R52, and beds. The 1/2 side Rail/E care) policy dated 7 assess the resident 1/2 side rails/enable the staff to ensure the residents. SUGGESTED MET The environmental safety of each enable environmental direct bars and apply ena- manufacturer's reco Assessment and As- could do random at	Ige 27 Jactured rails had been ot to reduce the rails. The DES as currently in the process of options which were equipped nd they had received approval they were not currently in ve enabler bars were not P.m. licensed practical nurse list which identified the facility sident beds equipped with had either been altered from original design or fabricated licated R38, R42, R37, R56, 3, R26, R48, R23, R58, R44, R2 all had altered rails on their nabler Use in LTC (long term 7/11, directed the staff to t upon admission for the use of ers. The policy did not direct the rails were safe for the THOD FOR CORRECTION: director could assess the oler bar in the facility. The ctor would remove any unsafe bler bars according to ommendations. The Quality ssurance (QAA) committee udits to ensure compliance. R CORRECTION: Twenty-one					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 28	2 905			
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			
	positioned in good of residents unable must be changed a including periods o been put to bed for has documented th hours during this tin	ng. Residents must be body alignment. The position a to change their own position at least every two hours, f time after the resident has the night, unless the physician nat repositioning every two me period is unnecessary or ordered a different interval.				
	by: Based on observat review, the facility f identified at risk for timely repositioning	ent is not met as evidenced ion, interview and document failed to ensure a resident pressure ulcers (PU) received for 4 of 5 residents (R38, ) in the sample identified at risk				
	Findings include:					
	recieve turning and	pressure ulcers and did not I repositioning assistance for minutes on 9/5/13, and two tes on 9/6/13.				
	ankle and upper ba	on 9/12/12, with a PU on her ack. R38 also had arterial peral vascular disease (PVD, a )).				
		f Pressure Sore Potential cated R38 was at risk for PU				
		num Data Set (MDS) dated R38 was cognitively intact,				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		00461	B. WING		09/	06/2013
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S			
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
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2 905	Continued From pa	age 29	2 905			
	repositioning and h	extensive assistance for ad two stage one PU's. The essment (CAA) dated 9/5/13, admitted with PUs.				
	indicated R38 was directed staff to ass offloading (presure	(POC) dated 8/28/13, at risk for pressure ulcers and sist with repositioning and relief) hourly during awake acked indication of R38's s when in bed.				
	On 9/4/13, at 10:01 tired from sitting in	a.m. R38 stated she did get her wheelchair.				
	on her back in bed. observed in bed, or - At 8:37 a.m. R38 remained on her ba continuously obser 9:47 a.m. - At 9:47 a.m. R38 bed. R38 stated sh R38 asked, "What observed continuou a.m.	a.m. R38 was observed asleep . R38 was continuously n her back until 8:37 a.m. was observed awake and ack in bed. R38 was ved in bed,on her back until was awake on her back in e was still waiting to get up. takes them so long?" R38 was usly on her back until 10:09				
	NA-C entered R38' - At 10:11 a.m. NA- the NAs assigned t - At 10:15 a.m. NA- her back at 7:00 a. every 2 hours. At th left side to receive	C stated her and NA-A were o the South wing. -C stated R38 was placed on m. and was to be turned in bec his time, R38 was turned to her cares. (3 hours and 15 min				
	so late?" - At 1:02 p.m. regis	ng). 3 asked NA-A, "Why are you stered nurse (RN)-A stated R38 sk for PU. RN-A stated R38				

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	TATE, ZIP CODE					
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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	
2 905	was to be offloaded wheelchair, and eve RN-A verified the re- while in bed was no On 9/6/13, at 8:36 a wheelchair at the b continuously obserr - At 9:27 a.m. the s R38 to her room. - At 9:35 a.m. R38 her wheelchair in h - At 9:38 a.m. activ exercise group in th continuously obserr - At 10:50 a.m. R38 from sitting. - At 10:53 a.m. NA- into the wheelchair h ad not been repose in the wheelchair. N repositioned every - At 10:55 a.m. R38 with NA-A and NA- / offloading. (2 hou repositioning). - At 11:00 a.m. NA- repositioning occur R15 did not receive for greater than fou 9/5/13. R15's diagnoses in disorder. The signif	d hourly when up in the ery two hours while in the bed. epositioning schedule for R38 of addressed on the care plan. a.m. R38 was observed in her reakfast table. R38 was ved until 9:27 a.m. ocial service designee brought was observed to remain up in er room. ity aide (AA)-A brought R38 to		DEFICIENC	Υ)		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		DDRESS, CITY, S			00/2010
		900 HILI		EVARD SOUTHEAST		
IRST C	ARE LIVING CENTER		N, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 31	2 905			
		l 8/13/13, indicated R15 was at ment of PU's due to urinary ecreased mobility.				
	dated 8/6/13, ident the development of Assessment dated	f Pressure Sore Potential form ified R15 at moderate risk for f PUs. The Tissue Tolerance 8/6/13, indicated R15 was ours without redness noted on				
	risk for the develop interventions such mattresses on the the POC did not dir	B/13/13, indicated R15 was at oment of PUs and identified as pressure reducing bed and wheelchair. However, rect the staff as to the R15 was to be repositioned.				
	in a wheelchair in t - At 7:50 a.m. R15 room for breakfast - At 8:24 a.m. R15 room and down the R15 was observed while in the main lo assistance. At no ti	was assisted to the dining				
		) a.m. NA-A stated R15 had ance with repositioning since of bed.				
	had assisted R15 c She confirmed R15 since that time. NA R15 to bed via a fu	-C stated other staff members out of bed around 6:30 a.m. 5 had not been repositioned -C and NA-A then assisted Il body mechanical lift. R15's served to be equipped with a				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2013	
		00461	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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
2 905	Continued From pa	age 32	2 905			
	pressure redistribution cushion. R15's skin was observed to be pink and intact free of pressure ulcers.					
	received assistanc	A-C confirmed R15 had not e with repositioning between 3 p.m. a total of 4 hours and 3				
		5 p.m. registered nurse (RN)-A receive assistance with r two hours.				
		e timely assistance with ad a history of PUs.				
	stroke and dement 6/25/13, indicated impairment and red with bed mobility, to and as being non a also indicated R55 development of pre- dated 4/9/13, indicated	included Alzheimer's disease, a ia. The quarterly MDS dated R55 had severe cognitive quired extensive assistance otal assistance with transfers ambulatory. The assessment was at risk for the essure ulcers. The PU CAA ated R55 was at risk for the essure ulcers due to decreased ive impairment.	1			
		f Pressure Sore Potential form cated R55 was at risk for the Js.				
	6/21/13, indicated	nce Assessment form dated R55 had the ability to sit for up ut the development of redness				
		essment and Interventions 8, indicated R55 had a history				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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	
2 905	Continued From pa	age 33	2 905				
	of PUs and require repositioning every	d staff to assist with two hours.					
	having a history of	4/10/13, identified R55 as PUs. The POC directed staff repositioning every two hours					
	nursing staff had ic left hip. The first ar (centimeters) and r was a 0.75 cm dry first area. The nurs dressing (thin prote	ated 8/24/13, indicated the dentified two open areas on the ea was approximately 2 cm red in color. The second area open area in the middle of the sing staff applied a Exuderm ective dressing) over the area nitor until the area had					
	main lobby, seated mechanical lift she resident. - At 7:35 a.m. R55 to her room by a la - At 7:45 a.m. R55 area. - At 7:55 a.m. R55 dining room for bre - At 8:32 a.m. R55	was wheeled from the dining					
	the lobby area unti and NA-C assisted mechanical lift. R5 be equipped with a	bbby area. R55 remained in 9:50 a.m. at which time NA-A R55 to bed via a full body 5's wheelchair was observed to pressure redistribution ve dressing was observed to eft hip.					
nnesota D	had been assisted	) a.m. NA-A confirmed R55 out of bed at 7:00 a.m. and ssistance with repositioning					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/	06/2013
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 34	2 905			
	since that time. A te minutes earlier.	otal of two hours and 50				
	risk for the develop was to be repositio p.m. RN-A observe the protective dres	D p.m. RN-A stated R55 was at oment of pressure sores and oned every two hours. At 2:50 ed R55's left hip and identified sing on the left hip. RN-A the dressing to assess R55's				
		) p.m. the DON reported the eft hip had been removed and resolved.				
	PUs and was not p	at risk for the development of provided timely assistance with e morning of 9/5/13, for three tes.				
	behavioral disturba quarterly MDS date severe cognitive in extensive assistant living, including ext mobility and total a MDS also indicated development of PL	acluded anxiety, dementia with ances and paranoia. The ed 7/9/13, indicated R29 had apairment and required ce with all activities of daily tensive assistance with bed ssistance with transfers. The d R29 was at risk for the Js. The PU CAA dated 4/21/13 at risk for the development of				
	risk for skin breakc	7/17/13, indicated R29 was at down and directed staff to oning every two hours.				
		f Pressure Sore Potential form ified R29 as being at high risk nt of PUs.				

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	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2013		
		00461	B. WING				
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION							
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	(X5) COMPLET DATE	
2 905	Continued From pa	age 35	2 905				
	The Skin Risk Assessment and Interventions form dated 7/8/13, identified R29 at high risk for the development of PU and directed staff to assist with repositioning every two hours while sitting or supine.						
	bed on his back. R bed, on his back un was observed to re cares. R29's skin v 9:20 a.m. R29 was	a. R29 was observed resting in 29 was observed to remain in ntil 9:10 a.m. at which time R29 eceive assistance with morning vas observed to be intact. At transferred from the bed via a al lift with the assistance of	)				
	been last assisted	a.m. NA-C stated R29 had with repositioning at 6:00 a.m. nd ten minutes earlier.					
		p.m. RN-A stated R29 was to with repositioning every two by the POC.					
	the Repositioning p directed the staff to	ent policy revised on 8/06, and policy revised on 6/2011, p provide assistance with rected by the resident's tent.					
	The director of nur and procedures rel cares to residents ulcers. The DON c	THOD FOR CORRECTION: sing (DON) could review policy lated to providing repositioning at risk of developing pressure ould educate staff on pressure I develop a monitoring system					

ATE SURVEY OMPLETED		E CONSTRUCTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ota Department of He NT OF DEFICIENCIES NOF CORRECTION	STATEMEN
9/06/2013	09/0		B. WING	00461		
		TATE, ZIP CODE	DRESS, CITY, S	STREET AD	PROVIDER OR SUPPLIER	NAME OF F
		EVARD SOUTHEAST	GOSS BOUL I, MN 56542		ARE LIVING CENTER	FIRST C
(X5) COMPLETE DATE	ON SHOULD BE IE APPROPRIATE	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ID PREFIX TAG	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENC)	(X4) ID PREFIX TAG
			2 905	ge 36	Continued From pa	2 905
				nsure compliance.	random audits to er	
				R CORRECTION: Twenty-one	TIME PERIOD FOR (21) days.	
			2 910	5 Subp. 5 A.B Rehab -	MN Rule 4658.0528 Incontinence	2 910
				Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.		
				ent is not met as evidenced on, interview and document ailed to ensure residents urinary incontinence received ith toileting and incontinence lents (R38, R15 and R29) in id as incontinent based on the sessment.	by: Based on observati review, the facility f identified at risk for timely assistance w care for 3 of 4 resid	
				on, interview and document ailed to ensure residents urinary incontinence received ith toileting and incontinence lents (R38, R15 and R29) in d as incontinent based on the	by: Based on observati review, the facility f identified at risk for timely assistance w care for 3 of 4 resid the sample identifie	linneedt D

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	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
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2 910	Continued From pa	age 37	2 910				
	R38 was incontinent of urine and did not receive incontinence care as directed by the plan of care (POC).						
	R38's diagnoses included a history of pressure ulcers, arterial disease and peripheral vascular disease (PVD, a circulatory problem).						
	6/25/13, indicated I bladder assessmen refused a toileting p change incontinent recommendations. Care Area Assessm	num Data Set (MDS) dated R38 was cognitively intact. The nt dated 6/25/13, indicated R38 program and staff continued to brief per manufacturer's The Urinary Incontinence nent (CAA) dated 9/5/13, episodes of bladder	3				
		7/3/13, directed staff to provide every 2-3 hours during the day.					
	on her back in bed observed in bed, or - At 10:09 a.m. nur NA-C entered R38 - At 10:11 a.m. NA- the NAs assigned t - At 10:15 a.m. NA- changed at 7 a.m. urine at that time. N incontinent brief wa hours. - At 10:20 a.m. NA- incontinent product	-C stated her and NA-A were	5				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		GOSS BOULI I, MN 56542	EVARD SOUTHEAST			
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2 910	Continued From pa	ge 38	2 910				
		receive incontinence cares ring the day. RN-A verified the red.					
		assistance with incontinence an four hours on the morning					
	disorder. The signif 8/6/13, indicated R <sup>-1</sup> impairment and rec with activities of data	cluded depression and anxiety icant change MDS dated 15 had severe cognitive juired extensive assistance ily living. The MDS also frequently incontinent of bowel					
	indicated R15 was	nence CAA dated 8/13/13, frequently incontinent of bowel rected staff to assist with every two hours.					
	Physical) Assessme R15 was incontiner required extensive	owel and Bladder History and ent dated 8/6/13, indicated nt of bowel and bladder and assistance of two staff to use the staff to assist R15 with every two hours.					
		/13/13, directed staff to assist ares every two hours.					
	main lobby seated i - At 7:50 a.m. R15 to the dining room f - At 8:24 a.m. R15 and down the hallw observed to fall ask	was observed to be assisted					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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(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 HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 39	2 910			
		) a.m. NA-A stated R15 had ance with incontinence since efore breakfast.				
	had assisted R15 of She confirmed R15 incontinence cares NA-A were then ob a full body mechan be wearing an inco saturated with uring confirmed R15 had incontinence cares p.m. a total of four On 9/5/14, at 12:35	C stated other staff members but of bed around 6:30 a.m. 5 had not been assisted with since that time. NA-C and served to assist R15 to bed via ical lift. R15 was observed to ontinence product which was e. At 10:40 a.m. NA-C I not received assistance with between 6:30 am. and 10:33 hours and three minutes. 5 p.m. RN-A stated R15 was to be cares every two hours as C.				
		e timely assistance with on the morning of 9/5/13.				
	behavioral disturba quarterly MDS data severe cognitive im extensive assistant living. The MDS als totally incontinent of Incontinence CAA	According to the second state of the second st				
		7/17/13, directed staff to assist cares every two hours.				
	identified R29 as b	essment dated 7/8/13, eing totally incontinent of ed assistance of staff to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/	06/2013
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 40	2 910			
	provide incontinend	ce cares every two hours.				
	bed on his back. R bed, on his back un received assistanc NA-A and NA-C. F	a. R29 was observed resting ir 29 was observed to remain in ntil 9:10 a.m. at which time R29 e with morning cares from R29 was observed to be der at the time of morning				
	been last assisted	a.m. NA-C stated R29 had with incontinence cares at 6:00 e hours and ten minutes				
		p.m. RN-A stated R29 was to with incontinence cares every ted by the POC.				
	12/05 and revised resident was incon with the inability to receive assistance	owel Assessment policy dated on 11/06 directed the staff if a tinent with no control present retain, the resident was to with having the incontinent ry two hours and changed as				
	The director of nur policies and proceed receive appropriate based on their asso Assessment and A	THOD FOR CORRECTION: sing or designee could review dures to ensure residents to toileting/incontinence care essed needs. The Quality ssurance (QAA) committee udits to ensure compliance.				
	TIME PERIOD FO (21) days. epartment of Health	R CORRECTION: Twenty-one				

STATE FORM

Minneso	ta Department of He	alth	-			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00461	B. WING		09/0	6/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condi part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the ss, and groom; d ambulate;	2 915			
	by: Based on observati review, the facility fa services according 1 resident (R13) in Findings include: R13's diagnoses in shortness of breath disease. The quart dated 8/20/13, indic intact and required mobility, transfer ar	cluded muscle weakness, and peripheral vascular erly Minimum Data Set (MDS) ated R13 was cognitively extensive assistance for bed				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING	B. WING		09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, S	TATE ZIP CODE			
				EVARD SOUTHEAST			
FIRST C	ARE LIVING CENTER		N, MN 56542	EVAND SOUTHEAST			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI		(X5) COMPLET	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE	
2 915	Continued From pa	ge 42	2 915				
	indicated R13 was	able to ambulate with assist of					
		hit belt and a four prong cane.					
		ated R13 had occasionally					
		hen ambulating but with					
		3, was able to ambulate.					
	R13's plan of care	(POC) dated 8/28/13, directed					
		im to a standing position and					
		cane to assist R13 to					
		eet or more 2-3 times per					
	week.						
		p.m. R13 stated he used to					
		but he had not walked as					
	much now because he required assistance with ambulation.						
	Review of Ambulati following informatio	on Roster identified the n:					
	times with distance	- 6/14/13, R13 ambulated five s varying from 10 feet to 50					
	feet.	0.0/01/10.010					
	feet two times.	3 - 6/21/13, R13 ambulated 20					
		3- 6/28/13, R13 ambulated 10					
	feet on one occasio	-					
		3- 7/5/13, R13 ambulated 25					
	feet on one occasio	-					
	The week of 7/6/13	- 7/12/13, R13 ambulated 15					
	feet on one occasio						
		3 - 7/19/13, R13 did not					
	ambulate.						
		3 - 7/26/13, R13 did not					
	ambulate.						
		3 - 8/3/13, R13 ambulated 35					
	feet on once occas						
		- 8/10/13, R13 ambulated 3 s varying from 10 feet to 100					
	feet.						
	epartment of Health						

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00461	B. WING		09/	09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER	900 HILL	IGOSS BOUL	EVARD SOUTHEAST			
		FOSSTO	N, MN 56542				
(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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	ige 43	2 915				
	feet one time. The week of 8/18/1 100 feet one time. The week of 8/25/1 times with distance feet. The week of 9/1/13 times with distance feet. The Ambulation Ro R13 had not ambul available," "refused weight bearing." On 9/6/13, at 8:10 a ambulate with resto (RNA)-A and nursir licensed practical n the wheelchair. R13 feet with assistance	3- 8/17/13, R13 ambulated 13 3 - 8/24/13, R13 ambulated 3 - 8/31/13, R13 ambulated 3 - 8/31/13, R13 ambulated 3 s varying from 50 feet to 200 - 9/6/13, R13 ambulated 3 varying from 55 feet to 125 ster documented reasons why ated were "unable," "not " or "was able to stand for a.m. R13 was observed to orative nursing assistant ng assistant (NA)-C with urse (LPN)-C following with 3 was able to ambulate 100 e.					
	stated R13 had occ but still had the abil low staffing pattern time to complete th confirmed R13 had	a.m. registered nurse (RN)-C casionally refused to ambulate, lity to walk. RN-C stated due to s, the staff did not have the e ambulation programs. She not consistently received ulate as directed by the POC.					
	restorative program implemented becau stated if the compu marked as refused have been due to th unable to ambulate have a restorative r	a.m. RNA-A stated the as had not been consistently use of short staffing. She ter documentation was , unavailable, or unable, it may he resident being physically e, or that the facility did not hursing assistant that day. She cumentation was completed,					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00461	B. WING		09/06/2013	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOULE N, MN 56542	VARD SOUTHEAST		
(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 HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 44	2 915			
	as to why the reside restorative program	dicated any further explanation ent did not participate in the n. She confirmed R13 had not t implementation of the n.				
	revised on 11/2002 assistance to ensur	am, Direct Care Staff policy , directed the staff to provide re the resident maintain the ge of motion and mobility as				
	The director of nurs review policies and residents receive a to the care plan. Th staff to ambulate re Assessment and As	THOD FOR CORRECTION: sing (DON) or designee could procedures to ensure mbulation services according the DON could train additional esidents. The Quality ssurance (QAA) committee udits to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
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:	ent is not met as evidenced ion, interview and document				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED		
		00461	61 B. WING		09/	09/06/2013		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ET ADDRESS, CITY, STATE, ZIP CODE					
	ARE LIVING CENTER			EVARD SOUTHEAST				
		FOSSIC	N, MN 56542					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE		
2 920	Continued From pa	age 45	2 920					
	with oral cares for sample who was de hygiene. In addition perineal care for 1 for incontinence ca Findings include: R29 did not receive the morning of 9/5/ R29's diagnoses in	e assistance with oral care on						
	anxiety. The quart dated 5/25/13, india cognitive impairme assistance with all MDS did not identif teeth. Review of the clinic	erly Minimum Data Set (MDS) cated R29 had severe nt and required extensive activities of daily living. The y any concerns with R29's cal record did not contain any						
	type of assessmen teeth.	t related to R29's oral cavity or						
	identified R29 as h	(POC) dated 7/17/13, aving upper and lower ted staff to assist with oral and as needed.						
	assistants (NA)-A a provide R29 total a R29's natural teeth blackened areas w between them. At 9	00 a.m. to 9:30 a.m. nursing and NA-C were observed to ssistance with morning cares. were observed with multiple ith white matter build up 0:27 a.m. NA-C offered R29 a at no time was R29 offered an h his teeth.						
	On 9/5/13, at 9:40 a	a.m. NA-C assisted R29 with						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 46	2 920			
		ning room. At 10:10 a.m. R29 e main lobby to participate in				
		C confirmed R29 had his own s had not been provided or ning cares.				
	verified R29 was to cares each mornin completing the MD instructed to physic	) p.m. registered nurse (RN)-A o receive assistance with oral g. She stated at no time when S / assessment had she been cally look into R29's mouth. s unaware if R29 had dentures				
	(DON) asked NA-A NA-A reported R29 majority of his teetl confirmed R29's Per reflected R29's cur	a.m. the director of nursing what type of teeth R29 had. may have a partial, but the were natural. The DON OC had not accurately rrent oral status and verified have been completed.				
	A policy regarding on the provided.	oral care was requested but				
		e assistance with perineal ntinent episode on 9/5/13.				
	disorder. The signi 8/6/13, indicated R impairment and rec with activities of da	Icluded depression and anxiety ficant change MDS dated 15 had severe cognitive quired extensive assistance ily living. The MDS also frequently incontinent of bowe				
	The Urinary Inconti epartment of Health	inence Care Area Assessment				

	NT OF DEFICIENCIES	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00461	B. WING		09/	09/06/2013	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		GOSS BOULE N, MN 56542	EVARD SOUTHEAST			
(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 HE APPROPRIATE	(X5) COMPLET DATE	
2 920	<ul> <li>(CAA) dated 8/13/1 frequently incontined directed staff to assessed every two hours.</li> <li>The B &amp; B H&amp; P (B Physical) Assessme R15 as being incom and required extensive use the toilet. The assist R15 with income hours.</li> <li>R15's POC dated 8 with incontinence c required extensive after each incontine</li> <li>On 9/4/13, at 10:33 R15 to bed via a full was observed to be product which was NA-A removed the clean brief. At no ti provide R15 with per At 10:40 a.m. NA-C received assistance being incontinent of On 9/5/14, at 12:35 receive perineal call episode as directed The Bladder and Be revised on 11/2006 manufacturer's guid</li> </ul>	3, indicated R15 was ent of bowel and bladder and sist with incontinence cares owel and Bladder History and ent dated 8/6/13, identified tinent of bowel and bladder sive assistance of two staff to assessment directed staff to assist ares every two hours and total assistance with pericares ent episode. 3 a.m. NA-C and NA-A assisted Il body mechanical lift. R15 e wearing an incontinence observed saturated with urine. soiled brief and applied a time did the nursing assistants erineal care. 2 confirmed R15 had not e with perineal cares after f urine. 5 p.m. RN-A stated R15 was to res after each incontinent		DEFICIENC			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00461	B. WING	B. WING		09/06/2013	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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 ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ige 48	2 920				
	The director of nurs review policies and residents receive o according to the ca provide an in-servic review oral hygiene Quality Assessmen	THOD FOR CORRECTION: sing (DON) or designee could procedures to ensure ral hygiene and perineal care re plan. The DON could ce for the nursing staff to and perineal care. The t and Assurance (QAA) o random audits to ensure					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	9				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en prevention and con E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the developp employee health po	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(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 DATE
21390	Continued From pa	ige 49	21390			
	H. a system for products which affed disinfectants, antised incontinence produ I. methods for current standards of This MN Requirement by: Based on observation review, the facility for infection control teo of 1 resident (R38) ulcer dressing char their hands after per (R29) observed recond Additionally, the fac bacillus (TB) common completed according					
	Findings include:					
	Licensed practical i to apply gloves. LP wash her hands pri LPN-A lifted R38's pillow. R38s right fo with kling.	o.m. R38 was observed in bed. nurse (LPN)-A was observed N-A was not observed to or to applying the gloves. right leg and placed it on a bot was observed wrapped				
	the door with her gl returned and took h the lock in R38's ni room again to get a	A left the room and touched oved hand, then immediately her medication cart key out of ght stand and then left the a scissor out of the medication LPN-A had not removed her				
	gloves, washed her	r hands nor apply clean gloves. A cut the kling off the right foot				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PREFIX TAG	· ·	/ 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	ge 50	21390			
	right malleolus (and spot on the second a scabbed area on telfa pad from the r area was observed - At 2:51 p.m. LPN- obtained a wet wipe blood from between then removed her g bathroom and applie washing was obser - At 2:53 p.m. LPN- package and applie on the dressing. - At 2:54 p.m. LPN- the room and went hallway. LPN-A the across the hall and wound cleanser and re-entered the room and then applied gl - At 2:57 p.m. LPN- the right malleolus applied the telfa dre - At 2:58 p.m. LPN- on, touched the door medication cart into - At 2:59 p.m. LPN- and laid them on th and checked the tre computer. - At 3:02 p.m. LPN- without washing he - At 3:03 p.m. LPN- kling and applied ta - At 3:05 p.m. LPN- placed them in the	A went into the bathroom and e. LPN-A then wiped dried in the 4th and 5th toe. LPN-A gloves and went into the ied new gloves. No hand ved. A opened up a telfa dressing ed Santyl (debriding) ointment A removed her gloves and left to the medication cart in the in went to the supply closet returned with a bottle of d gauze. When LPN-A in she did not wash her hands oves. A cleansed the open area on with wound cleanser, and essing. A left the room with her gloves or, and then brought her o the room. A then removed her gloves e top of the medication cart eatment order on the A went into the bathroom r hands and applied gloves. A wrapped the right foot with				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING	B. WING		06/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 51	21390			
	the soiled utility roo hands. - At 3:10 p.m. nursi LPN-A were going f - At 3:11 p.m. LPN- applied gloves. - At 3:13 p.m. LPN- that was in the gark up R38s pants. - At 3:15 p.m. LPN- washed her hands the faucet handles she had just washe - At 3:17 p.m. LPN- soiled utility room. On 9/4/13, at 3:18 p organized at all for stated she should h used hand sanitized dressing and apply stated there was h could have used. L would not have left LPN-A stated she h medication cart for unsure if it was clear clean the scissor w On 9/6/13, at 10:36 stated staff were to hand sanitizer after The Hand Washing staff were to decon having direct conta Decontaminate har	A put the garbage bag in the p.m. LPN-A stated she was not the dressing change. LPN-A have washed her hands or r after removing the soiled ing the new dressing. LPN-A and sanitizer in the room she PN-A stated normally she the room that many times. had used a scissor from the the dressing change, and was an. LPN-A stated she did not rith alcohol prior to using it. 6 a.m. the director of nursing b wash their hands or use r removing gloves. g Policy revised 5/04, indicated taminate their hands before	t			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
					03/	00/2013
	PROVIDER OR SUPPLIER		DRESS, CITY, ST	EVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER		N, MN 56542	LVAND SOUTHEAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		YMUST 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	ge 52	21390			
		personal cares with ashing on the morning of				
	behavioral disturbat quarterly Minimum indicated R29 had s and required extens activities of daily livi	cluded anxiety, dementia with nces and paranoia. The Data Set (MDS) dated 7/9/13, severe cognitive impairments sive assistance with all ing, including extensive I mobility and personal				
	indicated R29 was activities of daily livi dressing and transf	POC) dated 7/17/13, unable to care for himself with ing such as bathing, grooming, erring. The POC directed the stance with 1 -2 staff				
	and NA-C entered I morning cares. - At 9:07 a.m. NA-C R29 with washing h body. NA-A assisted needed to complete - At 9:11 a.m. NA-C and assisted with p observed to be inco small bowel movem to remove the soiled fresh incontinent br the same gloved ha curtain, open the ba soiled towels in a ba	rolled R29 onto his right side erineal cares. R29 was ontinent of urine and had a nent. NA-C was not observed d gloves prior to applying a ief. NA-C was observed with ands to move the privacy athroom door and place the ag and then returned to R29 ressing. She left her gloves				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390		age 53 al lift sheet under the resident.	21390			
	- At 9:20 a.m. NA-( assisted NA-A with the lift sheet. - At 9:22 a.m. NA-(	C moved R29's wheelchair and connecting the full body lift to C assisted to guide R29 into				
	NA-C tucked the lif	the same soiled gloves on. It sling under R29 and walked removed the gloves and				
	left the soiled glove	a.m. NA-C confirmed she had es on while she completed moving items in the room.				
	have removed her	p.m. RN-A stated NA-C should gloves and washed hands ultiple areas in the room.				
	directed staff to ch a contaminated bo the same resident.	policy revised on 2/2010, ange gloves when moving from dy site to a clean body site on The policy also directed the ash their hands after the				
	patient care reveal involving the lungs for the facility shou	a.m. the director of hospital ed the TB (contagious infectior ) community risk assessment Id be completed annually. 25 p.m. the director of hospital				
	patient care provid current TB risk ass 1/2011, which indic as low risk. The di	ed a copy of the facility's most sessment worksheet dated cated the facility was classified rector of hospital patient care the facility's most current TB				
pposota D	risk assessment. The facility's Aeros	ol Transmissible Disease Ilosis Control Plan dated				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ige 54	21390			
		he facility at a minimum, to sment of TB risk annually.				
	The administrator of policies and proceed infection control teo staff could be reed developed to ensur nursing (DON) could the director of hosp TB risk assessment Assessment and As	THOD FOR CORRECTION: or designee could review dures to ensure proper chniques are followed. Facility lucated and an auditing system re compliance. The director of ld establish a system to ensure pital patient care completed the t annually. The Quality ssurance (QAA) committee udits to ensure compliance.	,			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21405	MN Rule 4658.081 Tuberculosis Progr		21405			
	and as defined in M Health Informationa Prevention and Cor Homes, Minnesota	to Minnesota Rule 4658.0040, Minnesota Department of al Bulletin 09-02 Tuberculosis ntrol Guidelines: Nursing Rule 4658.0810 Subp 2 osis Program is waved.				
	Condition of Waive	r:				
	Prevention's "(Guid Transmission of My Health-Care Setting (No. RR-17), and a	enters for Disease Control and lelines for Preventing the vcobacterium tuberculosis in gs, 2005," (MMWR) 2005; 54 s subsequently amended, for poedures and requirements				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 09/06/2013	
		00461	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		900 HILL	IGOSS BOULI	EVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER	FOSSTO	N, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21405	Continued From pa	age 55	21405			
	("CDC Guidelines")	). Refer to the "CDC nplete definitions of terms.				
	tuberculosis (TB) ir program to appropriesponsibilities incli- infection control tea completion (and perisk assessment, a	tive responsibility for the nfection control & prevention riate personnel. Administrative ude establishment of an am (one or more individuals), eriodic review) of a written TB nd development (and periodic TB infection control plan.				
	by: Based on interview facility failed to ens R5, R27, R41) revie tuberculosis (TB) s Findings include: R1 was admitted to Review of the medi received step one of (TST) 1/22/2003. R3 was admitted to Review of the medi received step one of R5 was admitted to Review of the medi received step one of R5 was admitted to Review of the medi received step one of R27 was admitted to	ent is not met as evidenced r and document review, the ure 5 of 5 residents (R1, R3, ewed received the required creening upon admission. the facility on 1/22/2003. ical record indicated R1 of the tuberculin skin test the facility on 11/30/2009. ical record indicated R3 of the TST 11/30/2009. the facility on 3/2/2006. ical record indicated R5 of the TST 3/2/2006. to the facility on 11/10/2005. ical record indicated R27				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED		
		00461	B. WING		09/	09/06/2013	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER	2	IGOSS BOULE N, MN 56542	EVARD SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21405	Continued From pa	age 56	21405				
	Review of the med received step one of R1, R3, R5, R27, a lacked a comprehe screening for TB pi step one of the TS On 9/6/2013, at 10 (RN)-C confirmed to comprehensive bas assessment for res On 9/6/2013, at 11 patient care reveal baseline TB screen used for newly adm The facility's Manto 7/2009, directed st residents for curren disease.	27 a.m. registered nurse the facility lacks a specific seline TB screening sidents upon admission. 35 a.m. the director of hospita ed she was unaware of a ning assessment tool being nitted residents. bux Test policy revision date aff to assess newly admitted nt symptoms of active TB	1				
	The Director of Nu designee could mo procedures were d	onitor to assure TB screening eveloped and implemented to ee of TB prior to working with R CORRECTION:					
21415	MN Rule 4658.081 Tuberculosis Progr	5 Subp. 2 Employee am	21415				
	and as defined in M Health Information	to Minnesota Rule 4658 0040 <i>A</i> innesota Department of al Bulletin 09-02, Minnesota ubpart 2 Employee am is waived					

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	00461	B WING			
				09/06/2013	
	900 HILI				
ARE LIVING CENTER	2				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 57	21415			
Conditions of Waiver:					
"CDC Guidelines") screening. This scr assessment of any two-step tuberculir interferon gamma tuberculosis (e.g.,	must receive baseline TB reening must include a written current TB symptoms, and a skin test (TST) or single release assay (IGRA) for M. QuantiFERON® TB Gold or TE	3			
"CDC Guidelines") screening based o low risk - not need potential ongoing t Minnesota Departr	must receive serial TB n the facility 's risk level: (1) ed; (2) medium risk - yearly; (3 ransmission - consult the nent of Health's TB Preventior				
must receive follow according to current	v-up medical evaluation nt CDC recommendations for				
M. tuberculosis, more radiograph results	edical evaluation, and chest must be maintained in the				
consistent with TB physician within 72	must be evaluated by a hours. These HCWs must not	t			
	PROVIDER OR SUPPLIER ARE LIVING CENTER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa Conditions of Wai - All paid and unpa "CDC Guidelines") screening. This scr assessment of any two-step tuberculir interferon gamma tuberculosis (e.g., Gold - In Tube, T-S - All paid and unpa "CDC Guidelines") screening based o low risk - not need potential ongoing t Minnesota Departr and Control Progra - HCWs with abnor- must receive follow according to current the diagnosis of TE - All reports or cop M. tuberculosis, m radiograph results HCW's employee - All HCWs exhibi- consistent with TB physician within 72 return to work until	OU461           PROVIDER OR SUPPLIER         STREET A           ARE LIVING CENTER         900 HILL FOSSTO           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Image: Continued From page 57           Conditions of Waiver:         -           - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon garma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TE Gold - In Tube, T-SPOT ® .TB).           - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3 potential ongoing transmission - consult the Minnesota Department of Health's TB Preventior and Control Program at 651-201-5414.           - HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb           - All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW's employee file.           - All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must noi return to work until determined to be	O0461         B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, S'           ARE LIVING CENTER         900 HILLIGOSS BOULD FOSSTON, MN 56542           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG           Continued From page 57         21415           Conditions of Waiver:         - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB).           - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414.           - HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb           - All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW's employee file.           - All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be	Odd61         B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           ARE LIVING CENTER         900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX PREFIX CROSS-REFERENCED TO T DEFICIENCY           Continued From page 57 COnditions of Waiver:         21415         CONDITION ON THE SCHEME TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB).         - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414.         - HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb         - All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW's employee file.         - All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be         - All HCWs with abnormal TB	Image: Note of the second se

Minneso	ta Department of He	alth				120
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	,
		00461	B. WING		09/06/2013	8
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL N, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPL	ĹETE
21415	Continued From pa	ge 58	21415			
	by: Based on interview facility failed to ensu assistants (NA-E, N two-step tuberculin guidelines. Findings include:	ent is not met as evidenced and document review, the ure 2 of 5 newly hired nursing IA-F) were provided a skin test according to their				
	NA-E's tuberculin s indicated NA-E had on 8/5/13. This TS negative result. NA TST on 9/2/13, white one to three weeks	kin test documentation received step one of the TST T was read on 8/8/13, with a A-E received the second step ch was four days beyond the outlined in the facility's ning Tool for Healthcare				
	skin test documenta NA-F received step This TST was read result. NA-F receiv 8/22/13, which was three weeks outline	as 7/28/13. NA-F's tuberculin ation indicated one of the TST on 7/29/13. on 7/31/13, with a negative ed the second step TST on one day beyond the one to d in the facility's Baseline TB Healthcare Workers				
<i>t</i>	patient care confirm	a.m. the director of hospital ned if the second step TST in the three week timeframe, start over.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
FIRST C	ARE LIVING CENTER		GOSS BOULE N, MN 56542	EVARD SOUTHEAST		
(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 TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21415	The facility's Tubero 1/2009, indicated in be administered, re to current guideline The facility's Baseli Healthcare Worker perform the second weeks, if the first st SUGGESTED MET The director of nurs system to ensure e according to the fac Assessment and As could do random at	culosis Screening policy dated itial and follow-up TST shall ad, and interpreted according	21415			
21695	Subp. 4. Housekeep provide housekeep necessary to maint comfortable interior ceilings, registers, f and furnishings. This MN Requirement by: Based on observati failed to maintain re clean and sanitary marks for 7 of 28 re	5 Subp. 4 Plant eration, & Maintenance eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on and interview the facility esident bathroom walls in a condition free from black scuff esident bathrooms and 2 of 28 free from gouged, scratched	21695			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00461	B. WING		09/06/2013		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ET ADDRESS, CITY, STATE, ZIP CODE				
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21695	Continued From pa	age 60	21695				
	walls.						
	Findings include:						
	0	mental tour on 9/6/13, at 9:30 tor of environmental services g was observed:					
	marks on the bath Room #105 had m marks on the bath Room #106 had m marks on the bath Room #107 had m marks on the bath Room #108 had m marks on the bath the bed had gouge confirmed the goug have been from pu- clean. Room #128 had m marks on the bath Room #129 had m marks on the bath the bed had gouge the gouge marks a the area had been and scratched aga	ultiple areas of dark scuff room walls. ultiple areas of dark scuff room walls. ultiple areas of dark scuff room walls. ultiple areas of dark scuff room walls and the wall next to ed areas. At this time DES ge marks and stated it could ushing the bed into the wall to ultiple areas of dark scuff room walls ultiple areas of dark scuff room walls and the wall next to ed areas. The EDS confirmed and stated it appeared some of repaired but had been gouged in before it was ever painted.					
	approximately 10:0 housekeepers had they should be usin these black marks	he findings on 9/16/13, at 00 a.m. and stated l access to magic erasers and ng them when they notice . He added some areas need lled in and then painted.					
macrite D		provide a policy related to to fresident rooms or bathrooms					

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	IOI CONNECTION	DENTITION NOMBER.	A. BUILDING: _		COM	
		00461	B. WING		09/06/2013	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		IGOSS BOULI N, MN 56542	EVARD SOUTHEAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETI DATE
21695	Continued From pa	ige 61	21695			
	The director of envi provide education t housekeeping requ Assessment and As	THOD FOR CORRECTION: ironmental services could o staff regarding irements. The Quality ssurance (QAA) committee udits to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati failed to provide tim promoted dignity fo	ent is not met as evidenced ion and interview, the facility hely meals in a manner which r 3 of 3 residents (R13, R29, who did not receive breakfast.				
	Findings include:					
	R13 did not receive manner on the mor	e breakfast in a timely dignified ning of 9/4/13.				
	shortness of breath Set (MDS) dated 8/ and oriented, require	cluded muscle weakness and b. The quarterly Minimum Data (20/13, indicated R13 was alert red extensive assistance with ing and supervision with				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00461	B. WING		09/06/2013	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			00/2010
		900 HILI		EVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER	2	N, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 62	21805			
	eating.					
	R13 tolerated a reg	POC) dated 8/28/13, indicated gular diet and was independent e meal was set up by staff.	:			
	room, seated in a v (NA)-C stated R13 stated she was not breakfast or not. N into assisting him v cares to R13's root - At 9:25 a.m. NA-C opened the curtain R13 stated "I thoug me." NA-C assure R13 she would ass what he wanted to - At 9:30 a.m. R13 wanted to eat brea would be a long tin him she would brin	C completed cares on R29 and between the two residents. ght you had forgotten about d the resident and informed sist with breakfast and asked eat. stated he was not sure if he kfast. NA-C informed him it ne before lunch and assured ig him toast and coffee. NA-C				
	room. - At 9:40 a.m. NA-0 dining room. She coffee as she had - At 9:45 a.m. R13 towards the tub roo that he had not reo	was wheeled out of his room om. R13 explained to NA-D evive breakfast. NA-D				
	- At 9:47 a.m. NA-0 delivered toast and She was informed R13 will remind he bath.	R13 towards the tub room. C confirmed she had not coffee to R13 as promised. R13 was in the tub and stated r of the breakfast after his 3 was returned to his room				
nnesota De	from the tub room. - At 10:12 a.m. NA epartment of Health	-D reported R13 had refused				

STATE FORM

STATEME	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00461	B. WING		09/	09/06/2013	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010	
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21805	breakfast and he w stated she did not l received breakfast - At 10:20 a.m. R13 breakfast at the tak became tearful why why he did not alwa asked if he was hu was too late to eat lunch was served. offered to bring him returned with anyth late and he was "m On 9/4/13, at 11:30 the dining room an - At 12:06 p.m. R13 with his lunch, but a didn't get breakfast Un 9/4/13, at 12:49 stated she had bee received breakfast usually ate breakfast stated that was not stated R13 had not manner regarding b R29 did not receive 9/6/13. R29's diagnoses in behavioral disturba anxiety. The quart indicated R29 had and required exten activities of daily live	<ul> <li>vould wait until lunch. She know why R13 had not.</li> <li>3 stated he usually ate one when he was at home. He en he stated he did not know ays get breakfast. When ngry, R13 stated yes, but it it as it was only an hour until He confirmed the staff had not breakfast but they had not ning. R13 stated it was just too had."</li> <li>a.m. R13 wheeled himself to d received lunch.</li> <li>3 stated he was fully satisfied stated, "I don't know why I today."</li> <li>p.m. registered nurse (RN)-A en informed R13 had not this morning. She stated R13 ist in the dining room and t R13's normal routine. She t been treated in dignified</li> </ul>					

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED 09/06/2013	
	00461		B. WING		09/		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
FIRST C	ARE LIVING CENTER	2	IGOSS BOULI N, MN 56542	EVARD SOUTHEAST			
(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 HE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	age 64	21805				
	with meals as needed.						
	resting in bed with - At 9:00 a.m. R29 - At 10:15 a.m. R29 bed. - At 10:30 a.m. R29 received breakfast	was observed sleeping in bed. 9 continued to be sleeping in 9 remained in bed and had not 9 was observed in the dining					
	R15 did not receive 9/6/13.	e breakfast on the morning of					
	disorder. The signi 8/6/13, indicated R impairment and rec with activities of da	Icluded depression and anxiety ficant change MDS dated 15 had severe cognitive quired extensive assistance ily living. The MDS also able to feed himself.					
	feed himself after t	5/22/13, indicated R15 could he meal was set up by staff. staff to set up his meal and					
	breakfast meal in t	a.m. R15 was served his he dining room and was 0% of the meal independently.					
	resting in bed. At 9	a.m. R15 was awake and 9:00 a.m. R15 stated he was u.m. R15 was observed to have d.					
nnesota D	and R29 had not re	) a.m. NA-A confirmed R15 eceived their breakfast. NA-A vas short two NA's therefore,					

Minnesota Department of Health         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00461			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING		09/	09/06/2013		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
		900 HILL	IGOSS BOULE	EVARD SOUTHEAST			
	ARE LIVING CENTER	FOSSTO	N, MN 56542				
(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	
21805	Continued From page 65		21805				
	they were having di	fficulty keeping up with the nts. NA-A stated he would					
	On 9/6/13, at 10:20 a.m. dietary assistant (DA)-A stated she delivered the breakfast cart to the dining rooms at 7:30 a.m. and picked them up at 9:00 a.m. She stated she was not sure when the residents received their breakfast meals. She confirmed she had not been asked to leave a breakfast meal for R15 or R29.						
	manager (CDM) sta serving the resident residents were to b breakfast between would be served at p.m. supper at 4:30 was to be served at five meal plan the r up on their own and were ready. She sta residents' in the fact some sort of breakt residents were adm them what they like normal routines wh had eaten breakfass she confirmed she in the residents clin explained if the resi after 9:30 a.m. the something to eat ei rooms. The CDM w had not received br	a.m. the certified dietary ated the facility was currently ts on a five meal plan. The e offered a continental 7:30 a.m. to 9:00 a.m. lunch 11:00 a.m. snacks at 2:00 p.m. and a bedtime snack t 6:00 p.m. She stated with the esidents were allowed to wake d they could eat when they ated by 10:30 a.m. all of the sility should have been offered fast. She explained, when the nitted to the facility, she asked to eat and what was their ich included what time they t prior to admission. However, did not document the findings ical records. The CDM idents chose to stay in bed staff should be offering them ther in the dining room or their vas not aware R15 and R29 eakfast meals. The CDM ne snack documentation and R29 had received bedtime					

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	00461		B. WING		09/06/2013			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
FIRST C	ARE LIVING CENTER		GOSS BOULEVARD SOUTHEAST N, MN 56542					
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMP E APPROPRIATE DA			
21805	Continued From page 66		21805					
21805	On 9/6/13, at 11:00 observed to be sittin stated he had not ro 11:20 a.m. R15 and The LTC (long term Program and Dining 3/6/07, indicated th to receive 3 meals SUGGESTED MET The director of nurs services manager of staff regarding the to The Quality Assess committee could do compliance.	a.m. R15 and R29 were ng in the dining room. R15 eceived his breakfast meal. At d R29 were served lunch. a care) Resident Dietary g Experience policy dated he residents at the facility were	21805					
Mississes D	epartment of Health							