#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	-	_		AND TRANSMITTAL FE SURVEY AGENCY		ID: 5 Facili	5J6W ty ID: 00296
1. MEDICARE/MEDICAID PROVID (L1) 245428 2.STATE VENDOR OR MEDICAID (L2) 618245301		3. NAME AND ADDRESS OF FACILITY (L3) ESSENTIA HEALTH - HOMESTEAL (L4) 115 10TH AVENUE NORTHEAST (L5) DEER RIVER, MN			(L6) <b>56636</b>	<ol> <li>Initia</li> <li>Termi</li> <li>Valida</li> </ol>	ination 4. ation 6.	. Recertification . CHOW . Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Si 8. Full S	ite Visit 9. Survey After Comp	. Other plaint
6. DATE OF SURVEY 02/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>4/2015</b> (L34)(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE		EAR ENDING D. 2/31	ATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	32 (L18) 32 (L17)	Complianc1. A B. Not in Com		gram	And/Or Approved Waivers O  2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code  * Code: A	el6. S 7. M	g Requirements: Scope of Services Medical Director Patient Room Size Beds/Room	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF 32 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(	(L15)	
16. STATE SURVEY AGENCY REM See Attached Remarks	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION :	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL		Date:
Jana Bromenshenkel	, HFE NEII	0	2/11/2015	(L19)	Mark Meath	, Enforcem	ent Specialist	02/17/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	L OFFICE OR SINGLE	STATE AGE	ENCY	
19. DETERMINATION OF ELIGIBI  _X	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	21. 1. Statement of Fin 2. Ownership/Cont 3. Both of the Abov	rol Interest Discl		A-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	J:	(L30)	
OF PARTICIPATION <b>02/01/1987</b>	BEGINNING	DATE	ENDING DA	TE	01-Merger, Closure		INVOLUNTAR 05-Fail to Meet l	Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat		06-Fail to Meet	Agreement
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44)		04-Other Reason for Withdrawa	1	OTHER 07-Provider Stat 00-Active	tus Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				

(L33)

DETERMINATION APPROVAL

11/24/2014

(L32)

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

CCN: 24 5428

On February 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2015. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on February 4, 2015, as of January 2, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 2, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 11, 2014 and December 30, 2014. The CMS Region V Office concurs and has authorized this Department to notify the facility of these actions:

Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 3, 2015, be rescinded. (42 CFR 488.417 (b))

In our letters of December 11, 2014 and December 30, 2014, we advised the facility 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), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 3, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance on January 2, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b for the results of this visit.

Effective January 2, 2015, the facility is certified for 32 skilled nursing faclity beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245428

February 17, 2015

Mr. Michael Hedrix, Administrator Essentia Health - Homestead 115 10th Avenue Northeast Deer River, Minnesota 56636

Dear Mr. Hedrix:

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

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

Effective January 2, 2015 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meeth

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

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 11, 2015

Mr. Michael Hedrix, Administrator Essentia Health - Homestead 115 10th Avenue Northeast Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On December 15, 2014, This Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred with our recommendation and authorized this Department to notify you of the following:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 3, 2015. (42 CFR 488.417 (b))

Also, in our letter of December 15, 2014, 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 October 3, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on October 3, 2014 and lack of verification of compliance of the health deficiencies at the time of our December 15, 2014 notice. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On December 11, 2014 a Post Certification Revisit (PCR) was completed to verify you facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the October 3, 2014 standard survey. Based on our visit we had determined your facility had not achieved substantial compliance. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

Since your facility had not achieved substantial compliance, this Department imposed the Category 1 remedy of State monitoring, effective January 4, 2015.

In additional, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letter of December 15, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of this action:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 3, 2015, remain in effect. (42 CFR 488.417 (b))

Essentia Health - Homestead February 11, 2015 Page 2

On February 4, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 4, 2015, as of January 2, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 2, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 11, 2014 and December 30, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 3, 2015, 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 January 3, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 3, 2015, is to be rescinded.

In our letters of December 11, 2014 and December 30, 2014, 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 January 3, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 2, 2015, 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 visit with the President of your facility's Governing Body.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900

St. Paul, Minnesota 55164-0900 Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245428	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/4/2015
Name of Facility			Street Address, City, State, Zip Code	
ES	SENTIA HEALTH - HOMESTEAD		115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	

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) I	Date
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0205		01/02/2015		ID Prefix	F0250		01/02/2015		ID Prefix	F0282		01/02/2015
	483.12(b)(1)&(2)				•	483.15(g)(1)					483.20(k)(3)(ii)		_
LSC					LSC					LSC			_
ID Prefix	F0309		Correction Completed 01/02/2015		ID Prefix	F0314		Correction Completed 01/02/2015		ID Prefix			Correction Completed
Reg.#	-					483.25(c)				Reg. #			
LSC					LSC	403.23(0)							_
				-					-				_
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			P		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del> -
ID Prefix			Correction Completed		ID Prefix			Correction Completed		ID Prefix			Correction Completed
Reg. #					Reg. #								
LSC					LSC					LSC			_
Reviewed By	Revi	ewed B	Sy.	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	LI	3/mn	1	02	2/11/20	15		3260	01			02/04	/2015
Reviewed By	Revi	ewed B		Da	te:	Signature of	Surve	yor:				Date:	
Followup to	Survey Completed o			_			-				a Summary of to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

#### NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered February 10, 2015

Mr. Michael Hedrix, Administrator Essentia Health - Homestead 115 10th Avenue Northeast Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On February 10, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on February 3, 2015, imposed a daily fine in the amount of \$1000.00.

On February 3, 2015, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on February 4, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$1,000.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$620.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$1,620.60 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

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

Sincerely,

Mark Meath

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

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

cc: Program Assurance Unit

Penalty Assessment Deposit Staff

OrigRevisistLicPATALtr

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00296	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/4/2015
Name	of Facility		Street Address, City, State, Zip Code	
ES	SSENTIA HEALTH - HOMESTEAD		115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix	20565	Correction Completed 01/02/2015	ID Prefix	20830	Correction Completed 01/02/2015		ID Prefix	20900	Correction Completed 01/02/2015
Reg. #	MN Rule 4658.0405 Subp.	3	Reg. #	MN Rule 4658.0520 Subp.	1		Reg. #	MN Rule 4658.0525 Subp	. 3
LSC		-	LSC				LSC		- 
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #				Reg. #		
		-							_ 
		Correction			Correction				Correction
10 D C		Completed	10.0.6		Completed		1D D . C		Completed
		-					ID Prefix		_
Reg. # LSC		_	Reg. #				Reg. # LSC		_
		-							_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #		-	Reg. #						_
		-					LSC		_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #						
		-					LSC		- -
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
State Agency	, LB/mr	n	02/10/20		326	01		02/0	4/2015
Reviewed By CMS RO	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?					No		
	10/3/2014	5/00)		Page 1 of 1				Event ID: 5 I6W13	NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5J6W

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

	PART I -	TO BE COMPI	THE STAT	TATE SURVEY AGENCY Facility ID: 00296			
MEDICARE/MEDICAID PROVID     (L1) 245428     2.STATE VENDOR OR MEDICAID     (L2) 618245301		3. NAME AND AL (L3) ESSENTIA L (L4) 115 10TH AV (L5) DEER RIVE	HEALTH - HO VENUE NOR	OMESTEA	(L6) <b>56636</b>	4. TYPE OF ACT  1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey A	9. Other fter Complaint
6. DATE OF SURVEY 12/1  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	1/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	32 (L18) 32 (L17)	Complianc1. A  X B. Not in Com	nce With equirements the Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code  * Code: B*	6. Scope of 7. Medical	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 32 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM				DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Vienna Andresen, HFE	NEII	1	2/30/2014	(L19)	Mark Meath	, Enforcement Spe	<u>cialist</u> 01/30/2015 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	` ′	OFFICE OR SINGLE S	TATE AGENCY	(LZ0
19. DETERMINATION OF ELIGIBIDATE  1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WIT	H CIVIL	<ul><li>21. 1. Statement of Final</li><li>2. Ownership/Control</li><li>3. Both of the Above</li></ul>	ol Interest Disclosure St	
22. ORIGINAL DATE  OF PARTICIPATION  02/01/1987  (L24)	23. LTC AGREEI BEGINNING (L41)		4. LTC AGREEN ENDING DA (L25)		26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimburse	<u>INVOL</u> 05-Fail	(L30)  UNTARY  to Meet Health/Safety  to Meet Agreement
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	vider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)	Posted 02/09/202	15 Co.	
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAI	L DATE			
	(L32)	11/24/2014		(L33)	DETERMINATION APPL	ROVAL	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00296

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5428

On December 15, 2014, the Department recommended the following remedy to the CMS Region V office, who concurred with our recommendation and authorized this Department to notify the facility of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015.

The facility is subject to a two year loss of NATCEP beginning October 3, 2014, as a result of the extended survey that identified substandard quality of care (SQC).

This was based on the deficiencies cited by this Department during the extended survey completed October 3, 2014 and lack of verification of compliance with the health deficiencies at the time of our December 15, 2014 notice.

On December 11, 2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification. Based on our visit, we

have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 3, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being

F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiencies:

F0205 -- S/S: D -- 483.12(b)(1)&(2) -- Notice Of Bed-Hold Policy Before/upon Transfr

F0250 -- S/S: D -- 483.15(g)(1) -- Provision Of Medically Related Social Service.

The most serious deficiencies in the facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required. As result of our finding that your facility is not in substantial compliance, this Department imposed the category 1 remedy of State monitoring effective January 4, 2015. In addition, this Department recommended the following to the CMS Region V office

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015 remain in effect. (42 CFR 488.417 (b))

Furthermore, 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 October 3, 2014.

Refer to the CMS 2567b, CMS 2567 along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered December 15, 2014

Mr Michael Hedrix, Administrator Essentia Health - Homestead 115 10th Avenue Northeast Deer River, Minnesota 56636

RE: Project Number F5428023

Dear Mr. Hedrix:

On October 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on October 3, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), whereby corrections were required.

On November 18, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our extended survey, completed on October 3, 2014.

However, compliance with the health deficiencies issued pursuant to the October 3, 2014 extended survey has not yet been verified. The most serious health deficiencies in your facility at the time of the extended survey were found to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), 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 January 3, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 3, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Essentia Health - Homestead is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 3, 2014. 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.

#### **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.

### 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 April 3, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Lyla Burkman, Unit Supervisor Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Lyla.burkman@state.mn.us

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

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5428r1\_70day



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered December 30, 2014

Mr. Michael Hedrix, Administrator Essentia Health - Homestead 115 10th Avenue Northeast Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On December 15, 2014, the Department recommended the following remedy to the CMS Region V office, CMS concurred with our recommendation and authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015. (42 CFR 488.417 (b))

In addition, this Department notified you in our letter of December 15, 2014, 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 October 3, 2014.

This was based on the deficiencies cited by this Department during the extended survey completed October 3, 2014 and lack of verification of compliance with the health deficiencies at the time of our December 15, 2014 notice. The extended survey found the most serious deficiencies to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), whereby corrections were required.

On December 11, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 3, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being

F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiencies:

```
F0205 -- S/S: D -- 483.12(b)(1)&(2) -- Notice Of Bed-Hold Policy Before/upon Transfr F0250 -- S/S: D -- 483.15(g)(1) -- Provision Of Medically Related Social Service
```

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective January 4, 2015. (42 CFR 488.422)

In addition, this Department recommended the following action related to the imposed remedy in our letter of December 15, 2014:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015 remain in effect. (42 CFR 488.417 (b))

Furthermore, 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 October 3, 2014.

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.

#### 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.

#### **DEPARTMENT CONTACT**

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

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

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

### 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 April 3, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Weath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 01/20/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	JLTIPLE CONSTRUCTION (X: DING			X3) DATE SURVEY COMPLETED	
		245428	B. WING				R	
			b. WING			12/	11/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ESSENT	IA HEALTH - HOMES	TEAD			115 10TH AVENUE NORTHEAST			
				ı	DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMEN	TS	{F 00	00}				
	completed on 12/8 tags that were corr CMS2567B. Also the found corrected and the complete that the com	tification revisit (PCR) was - 12/11/14. The certification ected can be found on the here are tags that were not d new tags issued at the time ch are located on the						
	as your allegation of Department's acceenrolled in ePOC, at the bottom of the form. Your electron	of correction (POC) will serve of compliance upon the optance. Because you are your signature is not required the first page of the CMS-2567 nic submission of the POC will tion of compliance.						
F 205 SS=D	on-site revisit of yo validate that substate regulations has be your verification.	acceptable electronic POC, an ur facility will be conducted to antial compliance with the en attained in accordance with IOTICE OF BED-HOLD UPON TRANSFR	F 2	205			1/2/15	
	hospital or allows a leave, the nursing a information to the ro or legal representa of the bed-hold pol during which the re and resume reside the nursing facility's periods, which mus	acility transfers a resident to a a resident to go on therapeutic facility must provide written resident and a family member tive that specifies the duration icy under the State plan, if any, esident is permitted to return nce in the nursing facility, and is policies regarding bed-hold at be consistent with paragraph n, permitting a resident to						
I ABORATORY	 / DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE	

Electronically Signed 01/13/2015Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	E SURVEY IPLETED			
		245428	B. WING _			R <b>11/2014</b>	
	PROVIDER OR SUPPLIER	ΓEAD		STREET ADDRESS, CITY, STATE, ZIP COE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		12/11/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B				
F 205	At the time of trans hospitalization or the facility must provide member or legal re which specifies the described in paragi	_	F 20				
	facility failed to prove representative writt bed hold policy at the absences (LOAs) for reviewed who had a Findings include: R31's Physician Or 12/8/2014, identified diabetes, foot cellulopen wound on foot complication of dial and causes vision property (nerve disorder cautobacco dependent R31's admission M8/23/14, indicated Finds was independent with supervision for bed and personal hygie for mobility around indicated R31 had a her foot which required the Homestead Lings Resident Sign Outsigned herself out of 12/2/14. R31's Resident Propries Rational Ra	der Report dated 11/8/14 - d R31's diagnoses as itis/abscess (skin infection), t, diabetic retinopathy (a betes which affects the eyes problems), diabetic neuropathy ising decrease in sensation),		F 205 Element 1 Resident R31 has received a bed hold policy and is aware of hold option. The LSW along whave reviewed the bed hold pany LOA s.  Element 2 The bed hold policy was revier remains current. The resident book has been reviewed and going out on an LOA have recopy of the bed hold policy. A hold book has been revised to bed hold policy, sign out shee hold agreement to assure that residents going out on LOA have readents going out on LOA have recopy of the bed hold policy. The bed hold policy was revier remains current. Education has provided to nursing staff on the for bed hold and the resident shook.  Element 4 All resident LOAs will be audit	of the bed with nursing olicy with swed and a sign out all residents between a LOA/bed or include: of and bed trail ave a copy the policy.		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING				R <b>11/2014</b>
	PROVIDER OR SUPPLIER	read .		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	1 <i>L</i> /	11/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250 SS=D	the facility's bed howith R31 on the 35 herself out on an LC The social worker (Resident Progress focused on R31's filacked documentation provided to R31 respolicy.  On 12/8/14, at 3:02 nursing (DON) confust been initiated for On 12/9/14, at 8:55 on medical assistant of her 36 therapeut On 12/10/14, at 4:2 expectations would themselves out for review the bed hold this should be documedical record.  On 12/10/14, at 4:4 confirmed R31 had policy upon admissinformation on it sin The DEER RIVER Hold policy dated 1 admission the facilii the bed hold option therapeutic leave, the written notice to the member or legal reduration of the bed 483.15(g)(1) PROV RELATED SOCIAL	d policy had been reviewed occasions R31 had signed DA.  SW)'s entries written in the Notes from 8/26/14 - 12/5/14, nancial concerns; however ion regarding information garding the facility's bed hold p.m. the interim director of firmed the bed hold policy and or any of R31's LOAs a.m. the SW verified R31 was nee and that R31 had used 24 ic leave days.  9 p.m. the DON stated her be when someone signs an LOA that the nurse should policy with the resident and mented in the resident's  7 p.m. the consulting RN been provided the bed hold ion, however had not received ice.  HEALTHCARE CENTER Bed 2/18/2006, indicated upon the ty would notify the resident of and facility would provide in resident and a family presentative specifying the hold/therapeutic leave days.  ISION OF MEDICALLY	F 2		by the LSW or designee for 4 week monthly for 2 months and quarterly ongoing. Variances will be reported Administrator and reviewed at QAF least quarterly.	d to the	1/2/15

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	· ·	(X3) DATE SURVEY COMPLETED		
	245428	B. WING		R <b>12/11/2014</b>		
PROVIDER OR SUPPLIER	TEAD	1	15 10TH AVENUE NORTHEAST	12/11/2014		
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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
practicable physica well-being of each  This REQUIREME by:	ll, mental, and psychosocial resident.  NT is not met as evidenced	F 250				
facility failed to proservices related to coordination of leave of 1 resident (R31) on numerous occapreparation. In addup when R31 did nexpected. Findings include: R31's Physician O12/8/2014, identified diabetes, foot cellu open wound on foccomplication of dia and causes vision (nerve disorder cautobacco dependent R31's current physmetformin (oral diamilligrams (mg) dahydrocodone-aceta 5-325 mg as neede (antidepressant) 10 medication) 324 mg injection 12 units (ubefore the evening be done four times with dressing changes.	vide medically related social discharge planning and ves of absences (LOAs) for 1 reviewed who left the facility sions on LOA without adequate dition, the facility failed to follow ot return from her LOA when and R31's diagnoses as litis/abscess (skin infection), but, diabetic retinopathy (a betes which affects the eyes problems), diabetic neuropathy using decrease in sensation), and anemia. In addition, ician orders included betic medication) 1000 illy, aminophen (pain medication) ed every six hours, Celexa of mg daily, ferrous sulfate (iron g daily, humulin 70/30 insuling up in the morning and 8 u meal, blood glucose checks to a day, and daily wound care ge.		Element 1 Resident R31 has received a copy of bed hold policy and is aware of the bed hold option. The LSW along with number reviewed the bed hold policy wany LOA s. Discharge planning has occurred with R31 with the resident planning to return to the community.  Element 2 The bed hold policy was reviewed an remains current. The resident sign of book has been reviewed and all resigning out on an LOA have received copy of the bed hold policy. A LOA/behold book has been revised to included hold policy, sign out sheet and bed hold agreement to assure that all residents going out on LOA have a coff the same and are aware of the policy has a plant of the same and are aware of the policy and a conferences, upon request or as need the bed hold policy and discharge policies were reviewed and updated	ped rsing ith s  a a a a a a a a a a a a a a a a a a		
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENC' REGULATORY OR L  Continued From pa practicable physical well-being of each  This REQUIREME by: Based on interview facility failed to pro- services related to coordination of leav of 1 resident (R31) on numerous occa- preparation. In add up when R31 did n expected. Findings include: R31's Physician O 12/8/2014, identified diabetes, foot cellu open wound on foo complication of dia and causes vision ( nerve disorder cau tobacco dependent R31's current phys metformin (oral dia milligrams (mg) da hydrocodone-aceta 5-325 mg as neede (antidepressant) 10 medication) 324 mg injection 12 units (u before the evening be done four times with dressing chan- R31's admission M 8/23/14, indicated I	PROVIDER OR SUPPLIER  IA HEALTH - HOMESTEAD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility failed to provide medically related social services related to discharge planning and coordination of leaves of absences (LOAs) for 1 of 1 resident (R31) reviewed who left the facility on numerous occasions on LOA without adequate preparation. In addition, the facility failed to follow up when R31 did not return from her LOA when expected. Findings include:  R31's Physician Order Report dated 11/8/14 - 12/8/2014, identified R31's diagnoses as diabetes, foot cellulitis/abscess (skin infection), open wound on foot, diabetic retinopathy (a complication of diabetes which affects the eyes and causes vision problems), diabetic neuropathy (nerve disorder causing decrease in sensation), tobacco dependence and anemia. In addition, R31's current physician orders included metformin (oral diabetic medication) 1000 milligrams (mg) daily, hydrocodone-acetaminophen (pain medication) 5-325 mg as needed every six hours, Celexa (antidepressant) 10 mg daily, ferrous sulfate (iron medication) 324 mg daily, humulin 70/30 insulin injection 12 units (u) in the morning and 8 u before the evening meal, blood glucose checks to be done four times a day, and daily wound care with dressing change.  R31's admission Minimum Data Set (MDS) dated 8/23/14, indicated R31's cognition was intact, she	PROVIDER OR SUPPLIER  IA HEALTH - HOMESTEAD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility failed to provide medically related social services related to discharge planning and coordination of leaves of absences (LOAs) for 1 of 1 resident (R31) reviewed who left the facility on numerous occasions on LOA without adequate preparation. In addition, the facility failed to follow up when R31 did not return from her LOA when expected. Findings include:  R31's Physician Order Report dated 11/8/14 - 12/8/2014, identified R31's diagnoses as diabetes, foot cellulitis/abscess (skin infection), open wound on foot, diabetic retinopathy (a complication of diabetes which affects the eyes and causes vision problems), diabetic neuropathy (nerve disorder causing decrease in sensation), tobacco dependence and anemia. In addition, R31's current physician orders included metformin (oral diabetic medication) 1000 milligrams (mg) daily, hydrocodone-acetaminophen (pain medication) 5-325 mg as needed every six hours, Celexa (antidepressant) 10 mg daily, ferrous sulfate (iron medication) 324 mg daily, humulin 70/30 insulin injection 12 units (u) in the morning and 8 u before the evening meal, blood glucose checks to be done four times a day, and daily wound care with dressing change.  R31's admission Minimum Data Set (MDS) dated	PROVIDER OR SUPPLIER  1A HEALTH - HOMESTEAD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) (EACH DEFICIENCY) MISTER E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically related social services related to discharge planning and coordination of leaves of absences (LOAs) for 1 of 1 resident (R31) reviewed who left the facility an numerous occasions on LOA without adequate preparation. In addition, the facility failed to follow up when R31 did not return from her LOA when expected. Findings include: Findings		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7t. BOILD			F	3	
		245428	B. WING				1/2014	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				11	15 10TH AVENUE NORTHEAST			
ESSENT	IA HEALTH - HOMES	TEAD		D	EER RIVER, MN 56636			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
					DEFICIENCY)			
F 250	and personal hygie for mobility around indicated R31 had a her foot which requion 12/8/14, at 10:2 conference was he nursing (DON), corand administrator. DON stated on 12/2 LOA with an expect next day (12/3/14), returned on 12/3/14 thought R31 had repicked up her chec R31 had not return interim DON was u could be located. Someone doesn't reexpected, she would social worker and postated they had just that morning at state been done at that ti On 12/8/14, at 10:3 stated she was awathe facility. The SW to contact R31 on 1 however was unable her a message. The her call and had lef voice mail as the SThe SW confirmed where R31 could be to return to the facilion 12/8/14, at 10:5	mobility, dressing, toileting ne. R31 utilized a wheelchair the unit. In addition, the MDS an infected open skin lesion on ired daily dressing changes. 20 a.m. an entrance ld with the interim director of insulting registered nurse (RN), During this conference the 2/14, R31 had signed out on a ted return to the facility the The DON stated R31 had not 4, as planned, however; she eturned briefly on 12/6/14, k and left again. At this time, ed to the facility and the naware of where R31 currently The DON stated when eturn back from an LOA as ld get the ombudsman, the provider involved. The DON talked about R31's situation and up and nothing further had time. It a.m. the social worker (SW) are R31 had not returned to a confirmed she had attempted to 2/5/14, via telephone; le to speak with R31 and left to speak with R31 and le	F 2	550	discharge planning.  Element 4 All resident LOAs/discharges will be audited weekly by the LSW or desig for 4 weeks, monthly for 2 months a quarterly ongoing. Variances will be reported to the Administrator and reviewed at QAPI at least quarterly.  F250 Addendum Element 1 Resident R31 was educated on risk benefits of medication and treatment ordered by the MD. She was also educated and demonstrated an understanding of medications/inject and usage. R31 is aware to give nowhen going out to give time to prepher LOA in regards to meds and treatments. R31 was educated on the process of signing the book along when the total agreement for each LOA is went on, along with the number of constant of the significant planned and provide a contact number where she could be reached.  Element 3 All staff was educated on the proce what to do when someone does not from an LOA as scheduled to include the contact of the contact of the proce what to do when someone does not from an LOA as scheduled to include the contact of the proce what to do when someone does not from an LOA as scheduled to include the contact of the proce what to do when someone does not from an LOA as scheduled to include the contact of the proce what to do when someone does not from an LOA as scheduled to include the contact of the proces.	gnee and e  c vs. nts as  tions tice are for he with the she days 1 was tifying the to he ss of t return de		
	R31 on 12/6/14, ard	nad taken a phone call from bund 2 p.m. R31 was asking if t the facility. RN-A stated R31			contacting the resident/responsible initiating a wellness check as approand notifying the DON or LSW.			

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245428	B. WING				R <b>11/2014</b>	
	PROVIDER OR SUPPLIER	read .		STREET ADDRESS, CITY, STATE, ZIP 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	CODE		11/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  ID  PROVIDER'S PLAN OF CORRECTION  PREFIX  TAG  CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)		BE	(X5) COMPLETION DATE			
F 250	Duluth, but was back RN-A that she would Sunday (12/7/14). briefly about her for someone change the conversation RI documented in the nor was there an erthe day of R31's 12 education regarding supplies which may incase her dressing stated she was awathe facility on Saturacheck, and left again the time R31 return unaware if R31 had leaving again and/ohad been sent with medical record lack and 12/7/14). On 12/8/14, at 11:0 (LPN)-A stated on Thad sent with R31 a insulin syringes and LPN-A confirmed sincare or dressing chon 12/8/14, at 11:0 a resident doesn't r LOA, she would us resident or family, it would bring it to the document the incident had contact information DON if they needed the weekend or after not returned from a	ge 5 and that she had been in ck in Deer River now. R31 told d be back to the facility on RN-A stated she talked to R31 ot, and R31 stated she had ne dressing for her. However, N-A had with R31 was not medical record on 12/6/14, and the medical record on 12/6/14, told with regards to gwound care or wound care or have been sent with R31 needed to be changed. RN-A are that R31 had returned to day, 12/6/14, picked up her in. RN-A was not working at ed to the facility, and was been assessed prior to her if supplies and medications R31 when she left again (the red documentation on 12/6/14, on a.m. licensed practical nurse fuesday morning (12/2/14) she as vial of insulin, a couple of a day's worth of medication. The had not sent any wound anging supplies with R31. So a.m. RN-A confirmed when eturn to the facility from a utility attempt to call the facility attempt to call the fac	F 2	50				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		045400				R	
		245428	B. WING			12/1	11/2014
	PROVIDER OR SUPPLIER  IA HEALTH - HOMES	TEAD		1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROFIUE DEFICIENCY)			(X5) COMPLETION DATE
F 250	message she had r R31 on 12/5/14, sta R31 did not state w to the facility. The R31 to go out on ar return/date. If they would try to call R3 department and ha The SW stated if the then they would rep immediate report to (CEP). The SW ver wellness check on department for R31 been located at her facility on 12/8/14, it by the sheriff's department for R31 been located at her facility on 12/8/14, at 9:05 had not documente regarding her exter extended LOA's ca The Homestead Liv Resident Sign Out signed herself out of 12/2/14. The Resident Prog 12/2/14, indicated Fa a LOA 35 times. R31's Resident Prog on: 9/19/14, R31 had called and hadn't re evening. 9/20/14, (record indicated R31 had a a.m.	the facility.  a.m. the SW confirmed the received on her telephone from ated R31 was okay, however, when she planned on returning SW stated they have allowed a LOA with an open ended were worried about R31, they 1 or we would call the sheriff's we them do a wellness check. They were unable to locate R31, bort her missing and file an of the common entry point wrified she had initiated a 12/8/14, by the sheriff's  The SW confirmed R31 had be the home and had returned to the following the wellness check cartment.  The SW confirmed she will be the she she she she she she she she she s	F 2	250			

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING	B. WING		R <b>12/11/2014</b>		
	PROVIDER OR SUPPLIER	TEAD		1	STREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	1 2	11/2011	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 250	given something to foot dressing was or dirty and smelled for 10/6/14, R31 has noted that she and had not had he Friday morning (72 her left foot ulcer who brown with drainage During the dressing odor and a reddender of 10/19/14, R31 dressing changes of one to two times a 10/25/14, at 2: herself out on an Lareturned to the facion 10/28/14, R31 missed her clinic a 10/28/14, R31 evening and dressing was sature foul smell. 11/4/14, that do and not returning who seven doses of here as 4 centimeters (of with deepest depth was dark brown and the treatment on hed during this three data and this writer (SW and this writer (SW and the treatment on hed and this writer (SW and the treatment (SW and this writer (SW and the treatment of the foot of the streatment on he during this three data and this writer (SW and the treatment on hed of the streatment of	In not had supper. R31 was eat and her insulin. The left changed; the dressing was bul.  ad returned from a LOA. It had been incontinent of bowel er dressing changed since hours ago). The dressing on was documented to be dirty e and hanging off of her foot. It is change, there was a very foul ed color over the lower tendon. It is did not consistently receive her due to her being out on LOA week.  19 p.m. R31 had signed OA yesterday and had not lity yet. No phone calls either. remained on LOA and had popointment. Thad returned to the facility last ing change done this morning. The rated and continued to have a sure to R31 being out on LOA when she states she would, the received upon her return from a three asurements were documented as measuring 1.8 cm, drainage in the dressing that is the foot had not been done and anot been done and anot been able to follow ling her frustration that	F 2	250				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING			R <b>12/11/2014</b>		
	NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH - HOMESTEAD			STREET ADDRESS, 0 115 10TH AVENUE DEER RIVER, MM		<u>  12/</u>	11/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CO	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULE ERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 250	The SW's entries we Progress Notes from on R31's financial of documentation regarding and or addressing in needs when R31 wer The Care Conferen 11/11/14, indicated short-term basis, ho of a specific dischadon 12/10/14, at 4:2 documentation in Rinformation regarding R31's LOAs and the received in prepara On 12/10/14, at 4:2 discharge planning and be reviewed at the interdisciplinary development of the On 12/10/14, at 4:2 expectations would themselves out for provide the resident reatment supplies when they were gounderstood the care the resident was away where the resident expected return data should sign out on the bed hold policy resident. All of this documented in the On 12/10/14, at 4:3 verified the resident	rritten in the Resident m 8/26/14 - 12/5/14, focused concerns. The entries lacked arding a discharge plan, and the facility's bed hold policy, R31's social services medical as on an LOA. ce Report dated 9/9/14, and R31 was at the facility on a cowever, lacked documentation arge plan. 2 p.m. the DON verified the region of the record lacked and information pertaining to be care and treatment she tion for her LOAs. 6 p.m. the SW verified should start upon admission each care conference, and team was responsible for the discharge plan. 9 p.m. the DON stated her be when someone signs an LOA that the nurse should the enough medication and to care for their medical needs the he assured the resident the that needed to be done while way, a contact number of could be reached, and an reach care in addition, the resident the facility's sign out log and should be reviewed with the information should be resident record. 1 p.m. the consulting RN to LOA expectations outlined by d not been followed or		50				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245428	B. WING		R <b>12/11/2014</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	121	11/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 250 {F 282} SS=D	The Essentia Health Homestead DISCHARGE PLANNING policy dated 7/2013, indicated the SW functioned as the discharge planner for the facility. Upon admission the SW would meet with the resident and obtain a discharge plan. In addition, the SW would meet with the resident as needed to ensure the discharge plan was safe. The DEER RIVER HEALTHCARE CENTER Bed Hold policy dated 12/18/2006, indicated upon a therapeutic leave the resident would be provided a written notice which specified the duration of the bed hold/therapeutic leave days.  483.20(k)(3)(ii) SERVICES BY QUALIFIED		F 28			1/2/15
	review, the facility famonitoring had bee written care plan for facility that had a profile facility that had a pr	to the facility, and the Resident identified R34 had diagnoses were not limited to: Stage II teral paralysis, major r, atrial fibrillation, paranoia,		F282 Element 1 Resident R34 wound has a comprehensive skin risk completed care plan has been updated as appropriate. Weekly wound measures/protocol has been implemented.  Element 2 A base line skin audit was perform all residents to assure all residents compromised skin were being add All care plans were reviewed to assure addressed potential skin risk.	ed on with ressed. sure	

( )		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING			R <b>12/11/2014</b>		
	PROVIDER OR SUPPLIER	TEAD		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	<u>,</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 282}	The care plan date following: Resident and refusal to repo The care plan inter following: Resident pressure ulcers relations in the hospit Potential for further ongoing immobility incontinence and no repositioning and included: Assess that stage, size, weekly specialist, and treat Conduct a system about day. Report and for pressure ulcer do changes/monitoring wound specialist and ulcer.  The admission proposition of the following integrity: "Has exceed coccyx that measure by deep pink skin base of scrotum"  The physician progidentified that R34 pressure ulcers and the right buttocks we does continue to have in the right medial but redness of both measure with the residences, and the physician programmer.	d 11/10/14, identified the has history of pressure ulcers sition/adhere to care schedule. Ventions included the admitted with Stage II ated to immobility and loose al. Stage 2 on buttocks/coccyx. The pressure ulcers related to and bowel and bladder on-compliance with montinence care. Interventions he pressure ulcer for location, have seen by NP wound the per recommendations. Atic skin inspection weekly, on my skin concerns. Observe size aily with cares and dressing g, and report to physician or and worsening in the pressure of sollowing related to R34's skin priated area, stage 2, on res 3.5 X 3.2 cm surrounded and the surrounded. Has 0.7 X 0.2 open slit at	{F 28	32}	plans were updated as appropriate care plans have been implemented communicated to staff.  Element 3  Nursing staff were educated on the Comprehensive care planning produling with following the care plan/t sheets as appropriate.  Element 4  20% of resident skin care plan interventions will be monitored by the DON or designee for implementating weekly x 4 weeks, monthly for 1 monand quarterly ongoing. Variances are reported to the Administrator and reviewed at QAPI at least quarterly.	d and ecess eam the on onth, will be		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	COMPLETED			
		245428	B. WING	B. WING		R <b>12/11/2014</b>	
	NAME OF PROVIDER OR SUPPLIER  ESSENTIA HEALTH - HOMESTEAD			STREET ADDRESS, CITY, STA 115 10TH AVENUE NORTH DEER RIVER, MN 56630	EAST	<u>  12/</u>	11/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIV CROSS-REFERENCEI		BE	(X5) COMPLETION DATE
{F 282}	8/26/14, R34's presassessed on a wee are when the physic progress notes doc assessment:  - Physician progres days later)  - Physician progress - Physician progress - Nursing progress - Nursing progress later)  - Nursing progress later)  On 12/10/14, at 2:5 was observed and in open area on R34's area and off to the swas open, reddened appeared to be a stapproximately 3 cm of the R34's bottom coccyx and sacral avisualized.  Review of the Home Living Center policy Planning Process of addressed implement comprehensive care.  The consultant region 12/10/14, at 12:3 care plan for weekly	ysician progress note dated sure ulcers had not been kly basis. The following dates cian progress notes or nursing umented any pressure ulcer s note dated 10/23/14 (65 s note dated 10/27/14 s note dated 11/9/14 note dated 11/9/14 note dated 11/20/14 (21 days note dated 12/7/14 (18	{F 28	32}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3) G	(X3) DATE SURVEY COMPLETED		
		245428	B. WING _		R <b>12/11/2014</b>		
	PROVIDER OR SUPPLIER	TEAD		STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	12/11/2014		
(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 BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE		
{F 309} {F 309} SS=D	483.25 PROVIDE OF HIGHEST WELL BE Each resident must provide the necess or maintain the high mental, and psychological stress of the second stress of the se	CARE/SERVICES FOR	{F 309		1/2/15		
	by: Based on observareview, the facility for consistently been a measured, according resident (R31) who wound. Findings include: R31's Physician Or 12/8/2014, identified diabetes, foot celluropen wound on for complication of dia and causes vision (nerve disorder cautobacco dependent R31's admission M8/23/14, indicated was independent with supervision for bed and personal hygie for mobility around indicated R31 had her foot which required.	NT is not met as evidenced tion, interview, and record failed to ensure wounds had assessed, monitored and ng to facility policy for 1 of 1 o had a non-pressure related of the Report dated 11/8/14 - and R31's diagnoses as litis/abscess (skin infection), but, diabetic retinopathy (a betes which affects the eyes problems), diabetic neuropathy using decrease in sensation), and anemia. Linimum Data Set (MDS) dated R31's cognition was intact; she with transfers and required a mobility, dressing, toileting one. R31 utilized a wheelchair the unit. In addition, the MDS an infected open skin lesion on a lired daily dressing changes. The ted 10/1/14, identified a kin as R31 had been admitted		F309 Element 1 Resident R31 wound has been assess monitored and measured by the wound team, MD and WCC,NP. Care plan was reviewed and updated as appropriate.  Element 2 A base line skin audit was performed of all residents to assure all residents with compromised skin were being address according to current wound protocol.  Element 3 The wound policy and procedure was reviewed and updated to include skin risk/braden assessments, skin inspect on bath day, weekly wound documentation, and NP/MD notification Procedures were updated to reflect current standards of care. Education we provided to nursing staff.  Element 4 DON or designee will monitor all residents.	d ss		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING	B. WING		R <b>12/11/2014</b>	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	11/2014
					15 10TH AVENUE NORTHEAST		
ESSENTIA HEALTH - HOMESTEAD					DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
{F 309}	foot due to a punctudirected staff to kee possible, minimize streatment to the left physician. R31's Physician Or 12/8/14, directed st daily. The wound w wound cleanser; sk perimeter of the wo absorbent dressing wounds) dressing a lubricating jelly approvered with a gauz On 12/8/14, at 10:2 conference was hel nursing (DON), con and DON. During t (DON) stated on 12 a LOA with an expenext day (12/3/14). had not returned on however; she thoug 12/6/14, picked up this time, R31 had returned on however; she thoug 12/6/14, picked up this time, R31 had returned on however; she though this time, R31 had returned on however; she though 12/6/14, picked up this time, R31 had returned on however; she though 12/6/14, picked up this time, R31 had returned on however; she though 12/6/14, picked up this time, R31 had returned on however; she though 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12/6/14, picked up this time, R31 had returned on 12	al an open wound on her left are injury. R31's care plan up the wound clean and dry as skin moisture and to provide foot daily as directed by the der Report dated 11/8/14 - aff to change R31's dressing as to be cleansed with a in prep applied to the und; a Seasorb AG (an used for highly draining applied with wet saline; then a lied over the dressing, and are dressing.	{F 3	09}	with compromised skin weekly x 4 monthly for 2 months, and quarterly ongoing. Variances will be reported Administrator and reviewed at QAF least quarterly.	y I to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING			R <b>12/11/2014</b>		
NAME OF	PROVIDER OR SUPPLIER	210120			REET ADDRESS, CITY, STATE, ZIP CODE	12/	11/2014	
FSSENT	IA HEALTH - HOMES	ΓFΔD		11	5 10TH AVENUE NORTHEAST			
LOCENTIA TEAETT TIOMESTEAD				DI	EER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 309}	her call and had left voice mail as the SY. The SW confirmed where R31 could be to return to the facil On 12/8/14, at 10:5 (RN)-A stated she had any mail at said she was okay a Duluth, but was back RN-A that she woul Sunday (12/7/14). briefly about her foothad someone chan However, the converse was not documented 12/6/14, nor was the record on the day or egards to education wound care supplied with R31 incase her changed. On 12/8/14, at 11:0 (LPN)-A stated on 1 she had sent with F of insulin syringes a medication. LPN-A any dressing supplied on 12/9/14, at 10:1 observed to be a la wound on the bottom was observed to rule ended on the top of pink, there was no fall arge amount of sinterview with R31 as	e SW stated R31 had returned to a message on the SW's W had already left for the day, she currently was unaware of e located or when she planned ity.  3 a.m. registered nurse had taken a phone call from bound 2pm. R31 was asking if at the facility. RN-A stated R31 and that she had been in take in Deer River now. R31 told doe back to the facility on RN-A stated she talked to R31 bot, and R31 had stated she ge the dressing for her. Persation RN-A had with R31 and in the medical record on here an entry in the medical f R31's 12/2/14, LOA with an regarding wound care or s which may have been sent and dressing needed to be consistent of a couple and a day's worth of a confirmed she had not sent	{F 3	009}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		245428	B. WING _		12	R / <b>11/2014</b>		
	PROVIDER OR SUPPLIER	ΓEAD		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	(IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 309}	into a large gap. Rowas out on leave or have the dressing of supplies were not supplies not not supplies not not supplies not not supplies not not not supplies not	the left foot and it had grown 81 confirmed that when she f absence (LOA) she did not consistently changed because sent with for dressing changes. All often go to the clinic in the he lived to have the dressing nic was not open during ends so she did not have it see times.  In p.m. the director of nursing ne most current wound 831's wound on her left foot d on 11/15/14, and the re 4 centimeters (cm) x 8 cm x  ITIAL ADMISSION NURSING I form dated 8/19/14, indicated ressment section to "see note in documentation system). On mission note in the electronic	{F 309					

AND PLAN OF CORRECTION (X1		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING		R <b>12/11/2014</b>		
NAME OF I	PROVIDER OR SUPPLIER	210120		STREET ADDRESS, CITY, STATE, ZIP CO	DE	12/	11/2014
ESSENT	IA HEALTH - HOMEST	ΓEAD		115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
{F 309}	noted that she had had not had her dre morning (72 hours a foot ulcer was docu drainage and hangi dressing change, the a reddened color owneasurement was point, 9 cm in length.  R31's nursing heated 10/8/14, indictions a reddened color owneasurement was point, 9 cm in length.  R31's RPN dated dressing was saturated foul odor present. The was gaped open at lacked documentations. R31's RPN dated had received dressifted a received dressifted a found measureme and the same	we of absence (LOA). It was been incontinent of bowel and essing changed since Friday ago). The dressing on her left mented to be dirty brown with ng off of her foot. During the tere was a very foul odor and wer the lower tendon. The 1 cm in depth at the deepest and 4.5 cm in width. Home note from the physician eated R31's ulcer was "about 8 leep".  The distal end of the wound atted and continued to have a fine distal end of the wound ittle more than prior (this entry ion of a wound measurement). The measurements were m x 8 cm - irregular shaped measuring 1.8 cm, drainage do foul smelling. The distal end of the wound into the word of the word into the second second for the word in the word of the word in the word of	{F 30	09}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							٦
		245428	B. WING			12/1	11/2014
NAME OF I	PROVIDER OR SUPPLIER	l		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
FSSENT	IA HEALTH - HOMES	STEAD		1	115 10TH AVENUE NORTHEAST		
LOOLINI	IA IILALIII - IIOMLO	TEAD		[	DEER RIVER, MN 56636		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HAIE	DATE
{F 309}	Continued From p	age 17	{F 30	าดเ			
(. 000)	_ ·	_	\i 0	JJ			
	treatment had bee	s for December R31's foot					
		e time the reason documented					
		oot treatments was "resident					
		itional comments documented					
		Administration History record:					
		resident is LOA and do not					
	know when she wi						
		resident did not return from					
	LOA"	rociacin dia not rotarri nom					
		resident did not return from					
	LOA"	rocidoni dia not rotam nom					
	_	LOA since Friday 10/3/14"					
		"resident did not return from					
	LOA"						
		es (NN) dated 10/19/14,					
		scheduled for an appointment					
		a provider in the clinic to					
		oot wound as there had been no					
		ound healing. R31 had					
		d the surrounding tissue of the					
		ned significantly and the wound					
		ainage. In addition, the NN					
		d not consistently received her					
	wound treatment a	as she had been out on LOA					
	overnight approxing	nately one to two times a week.					
	R31's NN dated 11	1/15/14, at 1:06 p.m. indicated					
	R31 had returned	today after a three day LOA.					
		reatment on her foot had not					
		this three day absence.					
		iving & Rehabilitation Center					
		Sheet from September to					
	1	evealed R31 had signed herself					
		35 occasions. R31's medical					
		on to these LOA dates revealed					
		tation regarding what education					
		vided with regards to her					
		when she was out on an LOA					
	or if wound care s	upplies had been sent with R31					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245428	B. WING _			R / <b>11/2014</b>
	PROVIDER OR SUPPLIER	ΓEAD		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		711/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 309}	On 12/9/14, at 9:14 R31 had not had a assessment beyond used to assess a re developing a pressi identified at not bein pressure ulcer. On 12/10/14, at 3:5 would be her expect follow the facility's v stated wounds show measured weekly a documented in the On 12/10/14 at 4:0 nurse (CN) verified of R31's left foot wo 12/9/14, and the mod length, 3.5 cm in wi The DON and CN of the wound on R31's the first available mod the width of the wor 3 cm (an increase of On 12/10/14, at 4:1 facility did not have program in place to assessed, measure the facility's wound followed. On 12/10/14, at 4:2 her expectation wor was going out on a the medications and would need when the resident understood done while they we where the resident	change was needed. a.m. interim DON confirmed comprehensive skin d the 11/24/14, Braden (tool esident's level of risk for ure ulcer) which R31 had been ng at risk for development of a 5 p.m. the DON confirmed it etation that the staff would wound care policy. The DON uld be assessed and and this information should be medical record. 4 p.m. DON and consulting the most recent measurement ound was completed on easurements were 5.8 cm in idth and 0.07 cm in depth. confirmed the current width of as left foot had increased from leasurement of 8/27/14, where and had been documented as	{F 30	9}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		045400			R	
		245428	B. WING		12/11/2014	
NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTIA HE	ALTH - HOMES	ΓEAD		115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
inter be of DOI R31 R31 R31 Soro not how folloo The [uncinspressed as residued	locumented in to and CN verification and CN verifications. It is a Braden Scale at risk for development of the control of the control of the care at risk for development of the care at risk for development of the care at risk for development of the care at a control of t	all of this information should he medical record. The interimed this had not been done for	{F 30		een	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245428	B. WING				R 11/2014
	PROVIDER OR SUPPLIER	ΓEAD		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST EER RIVER, MN 56636	12/	11/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	Findings include:  R34 was admitted to Admission Record that included, but we pressure area, bilated depressive disorded neurogenic bladder.  The admission Min 8/25/14, indicated Frequired a wheelched extensive assistant and bed mobility, at ulcer (partial thickness a shallow open uprominence) at the The admission progene. Identified the fintegrity: "Has excococyx that measure by deep pink skin"  The physician progenessing dentified that R34 leaders of scrotum"  The physician progenessing dentified that R34 leaders of scrotum"  The physician progenessing the physician progenessing buttocks with a does continue to has his right medial but redness of both meaning the physician progenessing the physician pro	to the facility, and the Resident identified R34 had diagnoses were not limited to: Stage II reral paralysis, major r, atrial fibrillation, paranoia, r. dimum Data Set (MDS) dated R34 was unable to ambulate, air for all locomotion, required se of 2 persons for transfers and had one stage 2 pressure ess loss of dermis presenting ulcer usually over a boney	{F 3	14}	measures/protocol has been implemented.  Element 2 A base line skin audit was performed all residents to assure all residents compromised skin were being addressed according to current wound protocol.  Element 3 The wound policy and procedure were viewed and updated to include skrisk/braden assessments, skin insponibath day, weekly wound documentation, and NP/MD notificate Procedures were updated to reflect current standards of care. Education provided to nursing staff.  Element 4 DON or designee will monitor all rewith compromised skin weekly x 4 monthly for 2 months, and quarterly ongoing. Variances will be reported Administrator and reviewed at QAP least quarterly.	with essed ol.  as kin ection ation. in was sidents weeks, to the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING				ີ 11/2014	
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	<u>  12/</u>	11/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 314}	-The physician progindicated R34 had a sacral pressure ulcoseverity often due to offloading (allowing progress note ident R34's skin integrity: there is a stage I [in redness] ulcer. On area there is a quaistage I and stage 2 measured, nor was right buttocks addressing the control of the co	iil 10/23/14 (65 days later). gress note dated 10/23/14, a long standing history of ers that waxed and waned in this compliance with for reperfusion of skin). The iffied the following related to "Over his whole sacral area stact skin with non-blanchable the left upper thigh/gluteal fold the rize stage 2 ulcer." The ulcers had not been the pressure ulcer located essed as healed or not.  Gress note dated 10/27/14, ingrelated to R34's skin of approximately 3 X 3 x 0.1 to n the left ishium with some No surrounding erythema, ance."  Gress note dated 10/30/14, a stage 3 (full thickness tissue thich measured 3.5 cm X 3.5 anote dated 11/9/14, identified en area on crease between osterior thigh that measured and 0.5 cm deep. There was no stage 3 ischial ulcer previously	{F 3	14}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING				∺ 11/2014	
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	1 12/		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 314}	open area and 0.29 ulcer was noted be thigh that measure deep.  -Nursing progress later) identified that crease of the right measured 2 cm X nursing progress n 1 cm diameter sup	age 22 5 cm deep. Another pressure atween the right buttock and d 3 cm X 0.5 cm X 0.5 cm  note dated 12/7/14, (18 days t R34 had an open area in the buttock and thigh that 1 cm X 0.75 cm deep. The oted also identified R34 had a erficial open area with the toping proximal to the coccyx.	{F 3	114}				
	identified a pressur gluteal fold that me cm in depth. The d	ess note dated 12/9/14, re ulcer on the right posterior easured 2.7 cm X 1.5 cm X 0.5 ocumentation clearly showed a assessment and monitoring of ressure ulcers.						
	was observed and open area on R34' area and off to the was open, reddene appeared to be a sapproximately 3 cn of the R34's botton	54 p.m. the skin integrity of R34 it was noted that there was an s right side, below the anal side of the testicle. This area ed, with serous drainage and tage 2 ulcer, oval in size and in length by 2 cm. The rest in was reddened around the area - no other open areas						
	determine reposition 10/16/14, which iden been admitted with maceration noted cassessment indicate near the scrotum 2	assessment (used to oning needs) was completed on entified that the resident had a pressure ulcers and on the buttocks. The ted R34 had an open area 1.5 cm in length. Resident oftening and changing of brief during						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING				3	
		245428	b. WING			12/1	11/2014	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
FSSENT	IA HEALTH - HOMES	ΓFAD		1	115 10TH AVENUE NORTHEAST			
LOOLIVI	IA II LALIII - II OMLO			ı	DEER RIVER, MN 56636			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	NIAIE	57.11.2	
			ı					
{F 314}	Continued From pa	ne 23	{F 3	1/1				
(	·	_	ξi 3	143				
	R34 is reproached	When offloading was refused						
	assessment conclu							
	repositioning ever 1	-1.5 Hours.						
	The care plan dated	d 11/10/14, identified the						
		has chronic medical concerns						
		ent that involves paralysis of						
		and loss of the right arm. The						
		cted the spine and truck						
		has a neurogenic bladder						
		e of bowel and bladder.						
		y of pressure ulcers and						
		/adhere to care schedule. The						
		ons included the following:						
	Monitor skin for bre	akdown daily, encourage						
	repositioning per tis	sue tolerance. Resident						
		e II pressure ulcers related to						
		e stools in the hospital. Stage						
		x. Potential for further						
		ated to ongoing immobility and						
	bowel and bladder i							
	non-compliance wit							
		nterventions included: Assess						
		or location, stage, size,						
		by NP wound specialist, and						
	treat per recommer	der. Conduct a systematic						
		ekly, on bath day. Report any						
		erve size of pressure ulcer						
	daily with cares and							
		g, and report to physician or						
		nd worsening in the pressure						
		nd dry, Maintain the head of						
		st degree of elevation						
		reposition every 1.5 to 2 hours						
		ling of skin breakdown and						
		w skin breakdown. Resident						
		ositioning in this time frame.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245428	B. WING				₹
NAME OF I	PROVIDER OR SUPPLIER	240420	D. W		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	11/2014
ESSENT	IA HEALTH - HOMES	ΓEAD			I5 10TH AVENUE NORTHEAST EER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	statement signed or repositioning and relifting sheet to reposition with soft pil booties to feet.  The HOMESTEAD CENTER policy for (undated) indicated documentation wou wound tracking log as part of the qualit.  The consultant region 12/10/14, at 12:3 could not identify he had, when they dev because the documentation of R34's significantly lacking confirmed that R34'	explained. Risks and benefits in file. Staff will encourage eapproach as needed. Use sition resident in bed and illows and pressure relief  LIVING AND REHAB wound care procedures that wound assessment and illowed be completed weekly and a would be completed weekly assurance program.  Stered nurse was interviewed 66 p.m. and stated that she ow many pressure ulcer's R34 reloped, or when they healed inentation for assessment and pressure ulcers were. The RN consultant is wound assessment and not been completed	{F3	14}			

### Form Approved OMB NO. 0938-0390

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

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

(Y1) Provider / Supplier / CLIA / Identification Number 245428	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/11/2014
Name of Facility		Street Address, City, State, Zip Code	
ESSENTIA HEALTH - HOMESTEAD		115 10TH AVENUE NORTHEAS	ST

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	F0279 483.20(d), 483.20(k		Correction Completed 11/12/2014	ID Prefix Reg. # LSC	F0322 483.25(q)(2)		Correction Completed 11/12/2014		ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 11/12/2014
ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 11/12/2014	ID Prefix Reg. # LSC	F0356 483.30(e)		Correction Completed 11/15/2014		ID Prefix Reg. #			Correction Completed 11/12/2014
ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 11/12/2014	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 11/12/2014		ID Prefix Reg. # LSC	F0497 483.75(e)(8)		Correction Completed 11/12/2014
ID Prefix Reg. # LSC			Correction Completed	Reg. #								
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC								
Reviewed E	By Revie	ewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
State Agen	cy LB	/mm	ı	12/30/20	14	18	8617				12/	11/2014
Reviewed E	By Revie	ewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
Followup t	o Survey Complete 10/3/2014		:		Check for an Uncorrecte					Summary of the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

#### NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on February 3, 2015

February 3, 2015

Mr. Michael Hedrix, Administrator Essentia Health - Homestead 115 10th Avenue Northeast Deer River, Minnesota 56636

Re: Project # S5428024

Dear Mr. Hedrix:

On December 11, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 3, 2014.

State licensing orders issued pursuant to the last survey completed on October 3, 2014 and found corrected at the time of this December 11, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on October 3, 2014, found not corrected at the time of this December 11, 2014 revisit and subject to penalty assessment are as follows:

20565 -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use - <u>\$300.00</u> 20830 -- MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General - <u>\$350.00</u> 20900 -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers - \$350.00

The details of the violations noted at the time of this revisit completed on December 11, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of **\$1,000.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed, delivered or emailed to:

Essentia Health - Homestead February 3, 2015 Page 2

Lyla Burkman, Unit Supervisor Bemidji Survey Team Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Lyla.burkman@state.mn.us

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

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Health Regulation, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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

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

Sincerely,

Mark Weath

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

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

Enclosure

cc: Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

(X6) DATE

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					R		
		00296	B. WING		12/11/2	2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ESSENT	IA HEALTH - HOMES	I FAD	AVENUE NO ER, MN 566				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE	
{2 000}	Initial Comments		{2 000}				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- 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	nether a violation has been compliance with all rule provided at the tagule number indicated below. In 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 fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	12/11/14. During the determined that the #0565, #0830, and This uncorrected or will be reviewed at	visit was completed on		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.		

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

**Electronically Signed** 01/13/2015

TITLE

STATE FORM 6899 If continuation sheet 1 of 18 5J6W12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		l F	2
		00296	B. WING		12/11/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	ΓΕΔΝ	AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	O) Continued From page 1 {2 000}					
	penalty assessmen	t/s.		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period Following Correction.  PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH	Tag." the tute/rule ies" ply" nis s which after the s veyors d of	
				STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.	O	
				THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS' STATUTES/RULES.	ON FOR	
{2 565}	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	{2 565}			1/2/15
		omprehensive plan of care I personnel involved in the i.				
	This MN Requireme	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM 6899 5J6W12 If continuation sheet 2 of 18

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
					   F	?
		00296	B. WING		12/1	1/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	(FAD	AVENUE NO ER, MN 566			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 565}	Continued From pa	ge 2	{2 565}			
	original licensing or remain in effect. Pe Based on observati review, the facility fa monitoring had bee	on the following findings. The der issued on 10/03/14, will enalty assessment issued.  on interview, and document ailed to ensure pressure ulcer n completed according to the r 1 of 1 resident (R34) in the ressure ulcer.		Corrected		
	Findings include:					
	R34 was admitted to the facility, and the Resident Admission Record identified R34 had diagnoses that included, but were not limited to: Stage II pressure area, bilateral paralysis, major depressive disorder, atrial fibrillation, paranoia, neurogenic bladder.					
	following: Resident and refusal to reposition the hospital pressure ulcers relastools in the hospital Potential for further ongoing immobility incontinence and no repositioning and in included: Assess the stage, size, weekly, specialist, and treat Conduct a systema bath day. Report ar of pressure ulcer day changes/monitoring	d 11/10/14, identified the has history of pressure ulcers sition/adhere to care schedule. Ventions included the admitted with Stage II ated to immobility and loose al. Stage 2 on buttocks/coccyx. pressure ulcers related to and bowel and bladder on-compliance with icontinence care. Interventions he pressure ulcer for location, have seen by NP wound a per recommendations. Itic skin inspection weekly, on my skin concerns. Observe size ally with cares and dressing g, and report to physician or and worsening in the pressure				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		00296	B. WING			1/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	ESSENTIA HEALTH - HOMESTEAD 115 10TH DEER RI			PRTHEAST 636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 565}	Continued From pa	age 3	{2 565}			
	p.m. identified the fintegrity: "Has excococcyx that measu	gress note dated 8/18/14, 5:09 following related to R34's skin priated area, stage 2, on res 3.5 X 3.2 cm surrounded .Has 0.7 X 0.2 open slit at				
	The physician progress note dated 8/26/14, identified that R34 had been evaluated for pressure ulcers and indicated "forestage 2 on the right buttocks with a stage 1 surroundingHe does continue to have a small stage 2 ulcer on his right medial buttocks, as well as surrounding redness of both medial buttocks and the coccyx."					
	notes, and the phys 8/18/14-12/9/14, re aforementioned ph 8/26/14, R34's pres assessed on a wee are when the physi progress notes document assessment: - Physician progress days later) - Physician progress - Nursing progress - Nursing progress later)	lent's nursing home progress sician documentation from vealed that after the ysician progress note dated soure ulcers had not been ekly basis. The following dates cian progress notes or nursing cumented any pressure ulcer as note dated 10/23/14 (65 as note dated 10/27/14 as note dated 11/9/14 note dated 11/9/14 (21 days note dated 12/7/14 (18 days				
	was observed and open area on R34's area and off to the	64 p.m. the skin integrity of R34 it was noted that there was an s right side, below the anal side of the testicle. This area ed, with serous drainage and				

Minnesota Department of Health

STATE FORM 5J6W12 If continuation sheet 4 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						3
		00296	B. WING		12/1	1/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENTIA HEALTH - HOMESTEAD			AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 565}	Continued From pa	ige 4	{2 565}			
	approximately 3 cm of the R34's bottom coccyx and sacral a visualized.  Review of the Home	tage 2 ulcer, oval in size and in length by 2 cm. The rest in was reddened around the area - no other open areas				
	Planning Process d	y Comprehensive Care dated 11/12/14, had not enting the resident's e plan.				
	The consultant registered nurse was interviewed on 12/10/14, at 12:36 p.m. confirmed that R34's care plan for weekly assessment and measurement of pressure ulcers had not been followed according to the care plan.					
{2 830}	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	{2 830}			1/2/15
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on depreferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident in bed.				
	by:	ent is not met as evidenced on the following findings. The		Corrected		

Minnesota Department of Health

STATE FORM 599 5J6W12 If continuation sheet 5 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00296	B. WING		F <b>12/1</b>	<b>₹</b> 1/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	ESSENTIA HEALTH - HOMESTEAD 115 10TH DEER RI			ORTHEAST 636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	remain in effect. Per Based on observatireview, the facility from the facility from sistently been a measured, according resident (R31) who wound. Findings include: R31's Physician Or 12/8/2014, identified diabetes, foot cellul open wound on foo complication of dial and causes vision from the factor of the fa	der issued on 10/03/14, will enalty assessment issued.  ion, interview, and record ailed to ensure wounds had ssessed, monitored and ng to facility policy for 1 of 1 had a non-pressure related  der Report dated 11/8/14 - d R31's diagnoses as litis/abscess (skin infection), t, diabetic retinopathy (a petes which affects the eyes problems), diabetic neuropathy using decrease in sensation),	{2 830}			
		ound; a Seasorb AG (an used for highly draining				

Minnesota Department of Health

STATE FORM 5J6W12 If continuation sheet 6 of 18

Minnesota Department of Health

Minnesota Department of Health		Г				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	2
	00296		B. WING			1/2014
			l		1 -/ 1	1/2011
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	ΓΕΔD	AVENUE NO			
DEER RIV		ER, MN 566	536			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	TIEGOE/TIOTTI OTTE	oo ibertii Tiita iiti Ofiiviitiioiti)	TAG	DEFICIENCY)	10/112	
()			()			
{2 830}	Continued From pa	ge 6	{2 830}			
	wounds) dressing a	pplied with wet saline; then a				
		lied over the dressing, and				
	covered with a gau					
	On 12/8/14, at 10:2					
	conference was hel	d with the interim director of				
	nursing (DON), con	sulting registered nurse (RN),				
	and DON. During t	his conference the interim				
	(DON) stated on 12	2/2/14, R31 had signed out on				
	a LOA with an expe	cted return to the facility the				
		The interim DON stated R31				
		n 12/3/14, as planned,				
		ht R31 had returned briefly on				
		her check and left again. At				
		not returned to the facility and				
		as unaware of where R31				
		ocated. The interim DON				
		one doesn't return back from				
		d, she would get the				
		ocial worker and provider				
		stated they had just talked				
		on this morning at stand up				
		had been done at this time.				
		4 a.m. the social worker (SW)				
		are R31 had not returned to confirmed she had attempted				
	,	2/5/14, via telephone;				
		e to speak with R31 and left				
		e SW stated R31 had returned				
		t a message on the SW's				
		W had already left for the day.				
		she currently was unaware of				
		e located or when she planned				
	to return to the facil					
		3 a.m. registered nurse				
		nad taken a phone call from				
		ound 2pm. R31 was asking if				
		the facility. RN-A stated R31				
		and that she had been in				
		ck in Deer River now. R31 told				
		d be back to the facility on				

Minnesota Department of Health

STATE FORM 5J6W12 If continuation sheet 7 of 18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
712 . 27	0. 00201.0		A. BUILDING:			
		00296	B. WING		F 12/1	२ 1/ <b>2014</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		115 10TH	AVENUE NO	PRTHEAST		
ESSENT	ESSENTIA HEALTH - HOMESTEAD  DEER RI					
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
{2 830}	Continued From pa	age 7	{2 830}			
{2 830}	Sunday (12/7/14). briefly about her for had someone chark However, the conversal was not documented 12/6/14, nor was the record on the day or regards to education wound care supplied with R31 incase her changed. On 12/8/14, at 11:0 (LPN)-A stated on she had sent with for insulin syringes a medication. LPN-A any dressing supple On 12/9/14, at 10:1 observed to be a lawound on the bottom was observed to rule ended on the top or pink, there was no a large amount of sinterview with R31 wound had started bottom and side of into a large gap. R3 was out on leave or have the dressing of supplies were not supplies were not supplies were not supplies were not supplied but the clipholidays and weeked changed during the On 12/8/14, at 3:45	RN-A stated she talked to R31 ot, and R31 had stated she age the dressing for her. ersation RN-A had with R31 ed in the medical record on are an entry in the medical of R31's 12/2/14, LOA with on regarding wound care or as which may have been sent or dressing needed to be an area of a confirmed she had not sent iter dressing needed to be an aday's worth of a confirmed she had not sent ites with R31.  In a.m. R31's foot wound was arge gaping irregular shaped of R31's left foot, the wound an up the side of the foot and an up the side of the foot and a fully that time, she stated the as a cut from a glass on the the left foot and it had grown at that time, she stated the as a cut from a glass on the the left foot and it had grown all confirmed that when she f absence (LOA) she did not consistently changed because sent with for dressing changes. Suld often go to the clinic in the she lived to have the dressing nic was not open during ends so she did not have it				
	measurements of F	R31's wound on her left foot ed on 11/15/14, and the				

Minnesota Department of Health

STATE FORM 5J6W12 If continuation sheet 8 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00296	B. WING		F 12/1	≀ 1/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	ΙΕΔΙ)	AVENUE NO ER, MN 566			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
{2 830}	Continued From pa	ge 8	{2 830}			
{2 830}	measurements wer 1.8 cm in depth. R31's 24 HOUR-IN DOCUMENTATION under the skin assematrix" (electronic creview of R31's adrecord dated 8/19/1 documentation of a skin concerns. R31's medical recoregards to mention R31's Hospital indicated R31's had measuring 6.5 x 3 created R31's Resident 9/22/14, indicated R50 hottom of her left for and 1 cm in depth. R31's RPN date measurement is 8.3 and 1 cm deep. Ye noted in areas through a returned from a leasuremed from a leasurement was foot ulcer was docudrainage and hanging dressing change, the a reddened color or measurement was point, 9 cm in length. R31's nursing from the strength of the strength	re 4 centimeters (cm) x 8 cm x  ITIAL ADMISSION NURSING I form dated 8/19/14, indicated essment section to "see note in documentation system). On mission note in the electronic 4, there lacked ny skin assessment and or rd revealed the following with of wound measurement:  Outpatient Visit dated 8/27/14, d an ulceration on her left foot cm with a depth of 2 cm.  Progress Notes (RPN) dated 831 had an open area on the pot measuring 5 cm x 8.5 cm and 9/29/14, indicated wound 3 cm in length by 5 cm across allow slough (dead tissue) ughout the wound and tendons and ver for absence (LOA). It was been incontinent of bowel and essing changed since Friday ago). The dressing on her left immented to be dirty brown with ng off of her foot. During the here was a very foul odor and wer the lower tendon. The 1 cm in depth at the deepest h and 4.5 cm in width. Home note from the physician cated R31's ulcer was "about 8".				
		ed 10/29/14, indicated and continued to have a				

Minnesota Department of Health

winnesc	Minnesota Department of Health						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
		00296	B. WING		F 12/1	<sup></sup> 1/ <b>2014</b>	
			l		1 - 1 - / 1	1/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ESSENT	IA HEALTH - HOMES	ΓΕΔD	AVENUE NO 'ER, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 830}	Continued From pa	ne 9	{2 830}	DETIGIENCY)			
(2 000)			[2 000]				
	was gaped open a lacked documentation. R31's RPN date had received dress from a three day LC documented as 4 c with deepest depth was dark brown and R31's RPN, date wound measureme 3.5 cm in width and indicated a 0.5 cm wound from the meclosest date, to the facility). R31's Treatment Ac from September to 10 out of 30 day treatment had been 9 out of 30 days treatment had been 7 out of 9 days treatment had been 15 out of 9 days treatment had been 16 on 19/13/14 - "reknow when she will 0 on 9/24/14 - "reknow when she will 0 on 10/4/14 - "reknow when she will 0 on 10/4/14 - "reknow on 10/5/14 - "LOA" 0 on 10/5/14 - "LOA"	ted 12/9/14, indicated her foot onts were 5.8 cm in length x 10.07 cm in depth (this increase in the width of the asurement done 8/27/14, the date R31 was admitted to the diministration History record December 2014, revealed: ys in September R31's foot missed ys in October R31's foot missed in November R31's foot missed for December R31's foot missed for December R31's foot missed time the reason documented of treatments was "resident ional comments documented Administration History record: esident is LOA and do not return" esident did not return from OA since Friday 10/3/14"					
	- On 11/11/14 - "    LOA"	resident did not return from					

Minnesota Department of Health

R31's nursing notes (NN) dated 10/19/14,

STATE FORM 5J6W12 If continuation sheet 10 of 18

Minnesota Department of Health

Minnesota Department of Health		1				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	₹
		00296	B. WING			1/2014
			l		1 -/ 1	1/2011
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	ΓΕΔD	AVENUE NO			
		DEER RIV	ER, MN 566	536		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	REGULATORT ON E	3C IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	INAIL	BALL
			_			
{2 830}	Continued From pa	ge 10	{2 830}			
	indicated R31 was	scheduled for an appointment				
	on 10/20/14, with a	provider in the clinic to				
	evaluate her left for	ot wound as there had been no				
	progress toward wo	ound healing. R31 had				
	increased pain and	the surrounding tissue of the				
	wound had darkene	ed significantly and the wound				
	had an odorous dra	inage. In addition, the NN				
	confirmed R31 had	not consistently received her				
		s she had been out on LOA				
		ately one to two times a week.				
		15/14, at 1:06 p.m. indicated				
		oday after a three day LOA.				
		eatment on her foot had not				
		nis three day absence.				
		ring & Rehabilitation Center				
		Sheet from September to				
		vealed R31 had signed herself				
		5 occasions. R31's medical				
		to these LOA dates revealed				
		ation regarding what education				
		ided with regards to her				
		when she was out on an LOA				
		pplies had been sent with R31				
	_	change was needed.				
		a.m. interim DON confirmed				
		comprehensive skin d the 11/24/14, Braden (tool				
		esident's level of risk for				
		ure ulcer) which R31 had been				
		ng at risk for development of a				
	pressure ulcer.	at hor tor development of a				
		5 p.m. the DON confirmed it				
		station that the staff would				
		vound care policy. The DON				
		uld be assessed and				
		and this information should be				
	documented in the					
		p.m. DON and consulting				
		the most recent measurement				
		ound was completed on				

Minnesota Department of Health

STATE FORM 5J6W12 If continuation sheet 11 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. Bolebina.		R	
00296		B. WING	<del></del>		1/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	ΓΕΔD	AVENUE NO			
			ER, MN 566			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 11	{2 830}			
{2 830}	12/9/14, and the melength, 3.5 cm in will The DON and CN of the wound on R31's the first available methe width of the words as cm (an increase of On 12/10/14, at 4:1 facility did not have program in place to assessed, measure the facility's wound followed.  On 12/10/14, at 4:2 her expectation words as going out on a the medications and would need when the resident understood done while they were where the resident expected date of reinterim DON stated be documented in the DON and CN verified R31's numerous LOR R31's Braden Scale Sore Risk tool date not at risk for devel however the plan of followed.  The Overview of word [undated] directed as inspection and documented in the Comprehensive procedure dated 11 purposes of the care	easurements were 5.8 cm in dth and 0.07 cm in depth. confirmed the current width of a left foot had increased from easurement of 8/27/14, where and had been documented as of 0.5 cm).  O p.m. the DON confirmed the a standardized wound care assure wounds were ad and monitored. In addition, care policy had not been  9 p.m. the interim DON stated ald be whenever a resident LOA they would be provided detreatment supplies they ney were on the LOA; the detreament the LOA; the difference and an turn from the LOA. The all of this information should he medical record. The interiment of the load of the load of the deep done for	{2 830}			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED	
						R	
		00296	B. WING		12/1	1/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ESSENT	IA HEALTH - HOMES	ΙΕΔΙ)	AVENUE NO 'ER, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 900}	Continued From pa	ge 12	{2 900}				
{2 900}	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	{2 900}			1/2/15	
	comprehensive resion of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent reloping.					
	by: Uncorrected based original licensing or	on the following findings. The der issued on 10/03/14, will enalty assessment issued.		Corrected			
	review, the facility famonitoring had bee according to the fac	on, interview and document ailed to ensure pressure ulcer n completed consistently sility policy for 1 of 1 resident that had a pressure ulcer.					
	Findings include:						
	Admission Record i that included, but w	o the facility, and the Resident identified R34 had diagnoses ere not limited to: Stage II eral paralysis, major					

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R	
	00296	B. WING		12/1	1/2014
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENTIA HEALTH - HOMEST	FΔD	AVENUE NO /ER, MN 566	_		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
neurogenic bladder.  The admission Minis 8/25/14, indicated R required a wheelchal extensive assistance and bed mobility, and ulcer (partial thickness a shallow open uprominence) at the from the admission progportion of the from tegrity: "Has excord coccyx that measure by deep pink skin	mum Data Set (MDS) dated R34 was unable to ambulate, air for all locomotion, required the of 2 persons for transfers and had one stage 2 pressure the ess loss of dermis presenting alcer usually over a boney time of admission.  The order of	{2 900}			

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	F	R	
		00296 B. WING 12/11				
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	(FAD	AVENUE NO ER, MN 566			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 900}	Continued From pa	ge 14	{2 900}			
{2 900}	there is a stage I [ir redness] ulcer. On area there is a qual stage I and stage 2 measured, nor was right buttocks addressight buttock areas in a central dark areas induration or fluctual stages of the physician progressight buttock and poright buttock and poright buttock and poright buttock and poright stages and stages and stages are stages a	attact skin with non-blanchable the left upper thigh/gluteal fold the rize stage 2 ulcer." The ulcers had not been the pressure ulcer located essed as healed or not.  Agress note dated 10/27/14, ing related to R34's skin of approximately 3 X 3 x 0.1 to note left ishium with some No surrounding erythema, ance."  Agress note dated 10/30/14, a stage 3 (full thickness tissue which measured 3.5 cm X 3.5 anote dated 11/9/14, identified en area on crease between osterior thigh that measured and 0.5 cm deep. There was no stage 3 ischial ulcer previously	{2 900}			
	R34's skin was con later) when a nursir R34 had a stage 2 position by the anus open area and 0.25 ulcer was noted be	ration regarding assessment of inpleted on 11/20/14, (21 daysing progress note identified that open area at the 12 o'clock is that measured 0.5 cm round from deep. Another pressure tween the right buttock and disciplinaries of the control of the				
	later) identified that crease of the right I	note dated 12/7/14, (18 days R34 had an open area in the buttock and thigh that cm X 0.75 cm deep. The				

Minnesota Department of Health STATE FORM

STATE FORM 5J6W12 If continuation sheet 15 of 18

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBERS			(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00296	B. WING	·····		R 1 <b>1/2014</b>		
	PROVIDER OR SUPPLIER	ΓΕΔD 115 10TH	DRESS, CITY, S AVENUE NO VER, MN 566					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
{2 900}	nursing progress not a cm diameter super layer of skin missing.  A physician progresidentified a pressurgulateal fold that me cm in depth. The dolack of consistent a multiple different procession of the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the second open area on R34's area and off to the sec	oted also identified R34 had a erficial open area with the top g proximal to the coccyx.  ss note dated 12/9/14, e ulcer on the right posterior asured 2.7 cm X 1.5 cm X 0.5 ocumentation clearly showed a ssessment and monitoring of essure ulcers.  4 p.m. the skin integrity of R34 t was noted that there was an eright side, below the analeside of the testicle. This aread, with serous drainage and rage 2 ulcer, oval in size and are in length by 2 cm. The rest in was reddened around the area - no other open areas  assessment (used to ning needs) was completed on ntified that the resident had pressure ulcers and in the buttocks. The ed R34 had an open area 5 cm in length. Resident often ing and changing of brief during when offloading was refused at a later time. The ded R34 required	{2 900}					

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION AND DED			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				R		
		00296	B. WING			1/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - HOMES	ΓFΔD	AVENUE NO ER, MN 566			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 DN	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETE DATE
{2 900}	Continued From pa	ge 16	{2 900}			
	strength. Resident affecting continence Resident has histor refusal to reposition care plan intervention. Monitor skin for bre repositioning per tis admitted with Stage immobility and loos 2 on buttocks/coccypressure ulcers relabowel and bladder non-compliance wit incontinence care lithe pressure ulcer f weekly, have seen treat per recommer supplements per or skin inspection weekly inspection weekly with cares and changes/monitoring wound specialist and ulcer. Keep clean at the bed at the lower possible. Turn and in order to aide head decrease risk of newill often refuse repositioning and relifting sheet to reposition.	has a neurogenic bladder e of bowel and bladder. y of pressure ulcers and hadhere to care schedule. The ons included the following: akdown daily, encourage sue tolerance. Resident e II pressure ulcers related to e stools in the hospital. Stage yx. Potential for further ated to ongoing immobility and incontinence and h repositioning and neterventions included: Assess for location, stage, size, by NP wound specialist, and notations. Nutritional der. Conduct a systematic ekly, on bath day. Report any erve size of pressure ulcer				
	CENTER policy for (undated) indicated	LIVING AND REHAB wound care procedures that wound assessment and ild be completed weekly and a				

Minnesota Department of Health

STATE FORM 5J6W12 If continuation sheet 17 of 18

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00296	B. WING			R	
NAME OF I				27ATE 7ID CODE	12/	11/2014	
	PROVIDER OR SUPPLIER	115 10TH	AVENUE NO	STATE, ZIP CODE DRTHEAST			
ESSENT	IA HEALTH - HOMES	ΙΕΔΙ)	/ER, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{2 900}	Continued From pa	 ige 17	{2 900}				
		would be completed weekly assurance program.					
	on 12/10/14, at 12:3 could not identify he had, when they dev because the docum	istered nurse was interviewed 36 p.m. and stated that she ow many pressure ulcer's R34 veloped, or when they healed nentation for assessment and					
	significantly lacking confirmed that R34	s pressure ulcers were  j. The RN consultant  's wound assessment and  I not been completed  cility policy.					

6899

Minnesota Department of Health STATE FORM

	State Form: Revisit Report								
(Y1)	Y1) Provider / Supplier / CLIA / Identification Number A. Building B. Wing			(Y3) Date of Revisit 12/11/2014					
Name of Facility			Street Address, City, State, Zip Code						
ESSENTIA HEALTH - HOMESTEAD			115 10TH AVENUE NORTHEAST						

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

DEER RIVER, MN 56636

(Y4) Item		(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	20302	Correction Completed 11/12/2014	ID Prefix 20	Correction Completed 11/12/2014	ID Prefix	Correction Completed 20930 11/12/2014
	MN State Statut			Rule 4658.0405 Subp.		MN Rule 4658.0525 Subp.
-	21390 MN Rule 4658.0	=		Correction Completed 11/12/2014 Rule 4658.1310 A.B.C	Reg. #	Correction Completed 11/12/2014  MN Rule 4658.1315 Subp.
ID Prefix Reg. #		Correction Completed 11/12/2014 415 Subp.	ID Prefix	Correction Completed	ID Prefix	Correction Completed
ID Prefix Reg. # LSC			Reg. #	Correction Completed	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC			Reg #	Correction Completed	Daa: #	Correction Completed
Reviewed E	cy Li	eviewed By B/mm eviewed By	Date: 12/30/2014 Date:	Signature of Surveyor:  18617  Signature of Surveyor:		Date: 12/11/2014  Date:
Followup to Survey Completed on:  10/3/2014  STATE FORM: REVISIT REPORT (5/99)				Check for any Uncorrected Defi Uncorrected Deficiencies (CI Page 1 of 1		

Form Approved OMB NO. 0938-0390

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

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245428	( <b>Y2) Multiple Constru</b> A. Building B. Wing	SING HOME	(Y3) Date of Revisit 11/18/2014		
Name	of Facility		Street Address, City, State, Zip Code			
ESSENTIA HEALTH - HOMESTEAD			115 10TH AVENUE NORTHEAST			
			DEER RIVER MN 56636			

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
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			11/18/2014		ID Prefix			11/18/2014		ID Prefix			11/18/2014
Reg. #	NFPA 101				•	NFPA 101				Reg. #	NFPA 101		_
LSC	K0052				LSC	K0062				LSC	K0069		_
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
ID Prefix					ID Prefix			=					
Reg. #					Reg. #					Reg. #			_
LSC				ļ	LSC					LSC			
			Camaatian					Carra atian					Competion
			Correction					Correction					Correction Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#			-		Reg. #			<u> </u>
LSC					LSC								_
				<del> </del>					+				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			•		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del> -
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
										`			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
Reviewed By	, R	Reviewed E	Ву	Da	te:	Signature o	f Surve	yor:				Date:	
State Agency	,	PS/mr	n	1	2/15/20	14	0.	3005				11,	/18/2014
Reviewed By	, R	Reviewed E	Ву	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of										
	9/30/20	014					-				to the Facility?	YES	NO
				_									

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5J6W

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

		PART	I - TO BE COMI	PLETED BY T	THE STAT	E SURVEY	AGENCY	!	Facility ID: 00296
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245428  2.STATE VENDOR OR MEDICAID NO.     (L2) 618245301			3. NAME AND ADDRESS OF FACILITY (L3) ESSENTIA HEALTH - HOMESTEAD (L4) 115 10TH AVENUE NORTHEAST (L5) DEER RIVER, MN			(1	L6) <b>56636</b>	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANG (L9)			7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 E			02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY  8. ACCREDITATION STATUS  0 Unaccredited  2 AOA	10/03/2014 S:  1 TJC 3 Other	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	E	FISCAL YEAR ENDING	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	CATION  32		X B. Not in Comp	ce With quirements Based On: cceptable POC	n		oproved Waivers Of Th Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code B*		etor
14. LTC CERTIFIED BED BRI 18 SNF (L37)	8/19 SNF 32 (L38)	19 SNF (L39)	ICF	IID (L43)		15. FACILITY	Y MEETS ) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCE See Attached Remarks  17. SURVEYOR SIGNATURE		PLICABLE S	SHOW LTC CANCELL.  Date:	ATION DATE):		18. STATE S	SURVEY AGENCY AI	PPROVAL .	Date:
Rebecca Habe	rle, HFE NI	EII	1	11/12/2014	(L19)		nforcemen		11/20/2014 (L20)
	PAR	T II - TO	BE COMPLETEI	D BY HCFA RI	EGIONAI	OFFICE O	R SINGLE STAT	TE AGENCY	
19. DETERMINATION OF EI  1. Facility is EI  2. Facility is no	igible to Participate	(L21)		PLIANCE WITH C	CIVIL			cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCF	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  02/01/1987  (L24)  25. LTC EXTENSION DATE	B (I	C AGREEMI EGINNING		4. LTC AGREEMI ENDING DAT (L25)		VOLUNTAR 01-Merger, C 02-Dissatisfa		0 INVOLUN' 05-Fail to M ent 06-Fail to M	(L30) TARY  Ieet Health/Safety Ieet Agreement
25. LIC EXTENSION DATE	A.	Suspension	of Admissions:	(L44) (L45)		04-Other Rea	son for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28		. INTERMEDIARY/CA	ARRIER NO.	(L31)	30. REMAR.	ks d 11/24/2014	4 Co.	
31. RO RECEIPT OF CMS-153	9 (L32		. DETERMINATION O	DF APPROVAL DA	(L33)	DETERM	INATION APPRO	OVAL	
						·			

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00296

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5428

On October 3, 2014 an extended survey was completed at this facility. The survey found deficiencies with the most serious to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy. In addition, conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. The facility has been given an opportunity to correct before remedies would be imposed. The facility is prohibited from conduct NATCEP training for two years, effective October 3, 2014. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Please note, the facility's ame has changed to Essentia Health - Homestead. Preveiously the facility's name was Homestead Rehabilitation and Liviing Center. Refer to the MN1513 confirming the facilty name change and notice from this office dated November 20, 2014 confirming the change has been completed.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 22, 2014

Mr. Michael Hedrix, Administrator Homestead Rehabilitation & Living Center 115 10th Avenue Northeast Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On October 3, 2014, an extended 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 a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), 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>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>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

<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, Supervisor Bemidji Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: Lyla.burkman@state.mn.us

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

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 12, 2014, the Department of Health will impose the following remedy:

Homestead Rehabilitation & Living Center October 22, 2014 Page 3

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 12, 2014 the following remedy will be imposed:

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

#### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Homestead Rehabilitation & Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective October 3, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

#### APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct oan extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, 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.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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

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

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

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

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

#### Original deficiencies not corrected

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

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

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

be imposed.

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

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

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

If substantial compliance with the regulations is not verified by January 3, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 3, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

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

Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 11/12/2014 FORM APPROVED OMB NO. 0938-0391

	AND DUAN OF CODDECTION DENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE IS 10TH AVENUE NORTHEAST IEER RIVER, MN 56636	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN  The facility's plan as your allegation Department's acceenrolled in ePOC, at the bottom of th form. Your electrobe used as verificated used used as verificated used used used used used used used us	of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required e first page of the CMS-2567 onic submission of the POC will ation of compliance.  If acceptable electronic POC, an our facility may be conducted to antial compliance with the even attained in accordance with even attained in accordance with the even attained in accordance with the even attained in accordance with the even attained in accordance with even attained in the assessment and revise the resident's evelop a comprehensive care dent that includes measurable etables to meet a resident's and mental and psychosocial intified in the comprehensive est describe the services that are attain or maintain the resident's exphysical, mental, and being as required under		000	CROSS-REFERENCED TO THE APPROP		
ARODATOR	be required under	services that would otherwise §483.25 but are not provided  DER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IPE		TITLE		(X6) DATE

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

(X6) DATE

**Electronically Signed** 

10/31/2014

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG	` '	(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10/0	03/2014	
	PROVIDER OR SUPPLIER	ION & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	· · · · · · · · · · · · · · · · · · ·		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	§483.10, including under §483.10(b).  This REQUIREMS by:	at's exercise of rights under g the right to refuse treatment (4).	F 2				
	Based on observerview, the facility address medication interventions to make residents (R31) we reviewed; failed to pain interventions R11) who had expedited a care plane residents (R9) who with hair care.	ation, interview and document failed to develop a care plan to ons and appropriate eet the needs for 1 of 5 hose medication regimen was a develop a care plan related to for 3 of 3 residents (R6, R25, pressed pain; and failed to an for hair care for 1 of 4 or routinely refused assistance		Element 1 Residents (R6, R25, and R1 comprehensive assessment assessment tool has been a updated and comprehensive have been developed and in Resident (R9) has been inte care plan is in place to enco highest level of hair care acc resident. Resident (R31) ha care plan to address the me regimen. The same residen been evaluated for wheel ch and the care plan has been	t of pain. The inalyzed and e care plans inplemented. erviewed and a urage the ceptable to the is an updated edication in (R31) has pair positioning		
	the use of Celexa milligrams (mg) di adjustment disord of Ferrous Sulfate twice daily to treat R31's physician's Ferrous Sulfate 3: physician's orders 10 mg daily.  At 8:44 a.m. regis Ferrous Sulfate at on the care plan. R6 experienced c	(an antidepressant) 10 aily for depressed mood and ler, and did not address the use (an iron supplement) 324 mg t a lack of red blood cells.  orders dated 9/10/14, directed 24 mg two times a day. R31's dated 9/16/14, directed Celexa  tered nurse (RN)-A verified the nd Celexa should be addressed  ontinued left leg pain and the address interventions to		Element 2 All resident care plans have reviewed and updated to ref appropriate pain management choices, medication regimer chair positioning.  Element 3 The facility is care planning been updated as necessary education has been provided nursing staff.  Element 4 20% of resident care plans weekly by the DON or design weeks, then monthly for 2 miles.	ent, hair care ent, hair care ens, and wheel  policy has and d to licensed  will be audited nee for 4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/	03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1′	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	alteration in comfor syndrome and must cerebral palsy. The anticipate her need manner. The care how to minimize ponon-pharmacologic R6's pain.  On 10/1/14, at 9:00 in a wheelchair in the cry with tears running staff. She stated, "were observed in the holding her head. A assistant (NA)-A washer to her room.  On 10/2/14, at 9:00 in a wheelchair in the cry, "Ey, ey, ey, oh looking for staff me my goodness" as significant staff.	and 6/4/14, identified an at related to carpal tunnel cle spasticity secondary to exare plan directed the staff to sand respond in a timely plan did not direct the staff attential pain nor did it include tal interventions to minimize a.m. R6 was observed seated the dining room. R6 began to only down her face calling out to oh, oh oh." No staff members the dining room as R6 cried a few moments later nursing talked up to R6 and escorted a.m. R6 was observed seated the dining room. R6 began to that leg." R6 turned her head mbers and began to cry "oh the shook her head.	F2	279	thereafter quarterly. Variances will reported to the Administrator for immediate follow up and reviewed QAPI at least quarterly.			
	in pain every day. I while sitting in her v receives pain medi but she often has to next medication. N	a.m. NA-A stated R6 cried out NA-A stated R6 will complain wheelchair. NA-A reported R6 cations for pain management o wait until it is time for the IA-A stated R6 frequently in her room waiting for the next						
	experienced pain in	a.m. R6 stated she her left leg every day and will e explained the Tylenol takes						

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIEF	ON & LIVING CENTER	,	115 1	EET ADDRESS, CITY, STATE, ZIP CODE 10TH AVENUE NORTHEAST ER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY 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) COMPLETION DATE
F 279	care of the pain for the pain in her left often has to watch dose of pain medi as a "toothache the stated the pain promany of the activity sometimes it was times it was being at an 8 of scale daily. R6 state to make sure she medications.  On 10/2/14, at 10: expressed pain in stated she attempher leg, but it usual extended relief. Sometimes of pain in the four hours to prome the four hours to prove the four hour	about an hour. R6 explained leg wakes her at night and she in the clock to wait for her next cations. R6 described the pain lat never goes away." She evented her from participating in ties in the facility because better in the chair and other in bed. R6 described the pain in go on a 0-10 (10 worst) pain lated she has to watch the clock is receiving her pain.  On a.m. NA-D stated R6 her left leg every day. She its to reposition R6 in bed or rub lated ally does not give R6 pain like stated R6 may have a few relief, but it did not last long.  In a.m. licensed practical nurse is reported complaints of pain like stated R6 will request pain will watch the clock waiting for loass before she can ask for the stated R6 was uncomfortable, "I is something to giver her relief."  20 a.m. the consultant RN erienced daily pain daily and the address pharmacological and ical interventions to R6's pain.	F 2	779			
		ated 8/5/14, did not address the gs due to edema, the use of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From pa	age 4	F 27	9			
	gain/edema, or the acetaminophen (Ty through pain. Nor non-pharmacologic other than ambulated R25's care plan las would be rated on as needed (PRN) related to the second part of the se	vienol) 650 mg for break did it address the use of cal interventions to relieve pain ion.  It revised 8/5/14, indicated pain a scale of 1-10 by resident and medications may be given. Atted R25 was to participate in ercises to decrease pain. For non-pharmacological ded on the care plan.  It visician's order report indicated feations included: methotrexate eat severe rheumatoid arthritis) jection every 7 days, Fentanyl irs 50 mcg/hr (hour), change					
	Percocet 5/325 mg acetaminophen 32 hours for minor or between scheduled not exceed 3000 m hours.	adex 10 mg every day, 1 tablet every 4 hours PRN, 5 mg two tablets PRN every 4 breakthrough pain and give d Percocet doses if needed. Do ng [acetaminophen] total in 24					
	stated she had disc Review of the EMA a.m. PRN Percoce	n 9/30/2014, at 7:42 p.m. R25 comfort in both of her legs. R indicated on 10/1/14, at 1:57 t 5/325 mg. one tablet was g, and right and left heel pain.					
	stated as she lay in hurts." Surveyor as anybody and she s	n 10/1/2014, at 7:05 a.m. R25 n bed moaning "oh my leg sked her if she had told tated, "No, they know and all 7:15 a.m. R25 stated both of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/	03/2014
	ROVIDER OR SUPPLIER	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	them." At that time showed the survey and firm to the tou At 7:45 a.m. nursir observed assisting stated her groin/cr so tight. At 7:50 a. transferred from to NA-D stated, "Oh to NA-D sta	v are hard as a rock, just feel R25 removed her covers and vor her legs that appeared shiny ch.  Ing assistant (NA)-D was R25 wash up for the day. R25 otch area was swelled up and m. R25 stated as she bilet to w/c, "oh my knees hurt."	F 2	279			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING		10/	03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 279	Continued From pa	age 6	F 279				
	identify or address	ts. The care plan did not R11's right knee/joint pain, nor harmacological interventions					
	her room, seated in had been having a knee and raised he began to rub it. The swollen. R11 state the knee pain and "but they don't last 10/1/14, she was ghelped for a little bup at night at times was "up a lot" until stated the pain me hours before her kalso stated she asle	4 a.m. R11 was observed in a recliner. R11 stated she lot of problems with her right or pant leg above her knee and he knee was observed to be and she was given pain pills for stated they lasted a little while forever." She stated that on given cold packs and that it. R11 stated the pain kept her is and the previous night she she finally got a pain pill. R11 dication lasted for about 4 nee began hurting again. R11 ked for a pain pill a couple of entified her pain right now at an to 10 scale.					
	ambulating back to R11 was observed	10:02 a.m. R11 was observed oward her room after her bath. to be limping on her right leg. the felt much better after her					
	had pain daily and	10:48 a.m. NA-B stated R11 may have had more pain lately ping her right knee.					
	had pain every day for the pain. NA-D of any non-pharma relief of R11's pain	10:55 a.m. NA-D stated R11 and received pain medication indicated she was not aware acological interventions for the nor was she aware of factors l1's pain. NA-D further					

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVE' COMPLETED			
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	On 10/02/2014, at received scheduled day and could also her knee pain. LPI warm packs on her they had only done had been about a rhad been used. LF packs had been ef warm packs when indicated that if R1 in pain and had just instructed her to el until the medication.  On 10/02/2014, at consultant RN considentify intervention pain.  R9's care plan did of assistance with R9's Resident Admindicated R9 had dalzheimer's diseas disturbance, major hemiplegia (paralysbody), and polyneudamage causing nand sometimes pacaused by diabetes.  R9's quarterly Mini 8/30/14, indicated	n was mostly in her knees.  2:39 p.m. LPN-B stated R11 d pain medication three times a have PRN pain medication for N-B indicated R11 had used r legs previously, but stated so very occasionally, and it month since the warm packs PN-B indicated that the warm fective, and R11 had liked the used in the past. LPN-B 1 currently indicated she was at had a pain pill, they evate her legs and take it easy in worked.  3:12 p.m. interim DON and firmed the care plan did not ins to minimize R11's right knee not address her routine refusal hair care.  hission Record dated 10/2/14, hiagnoses that included e, dementia with behavioral depressive disorder, sis on one vertical half of the propathy in diabetes (nerve umbness, loss of sensation in feet, legs and hands	F 2	279			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		115	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST ER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	two staff for persor R9's activities of da Care Area Assessr indicated R9 had I weakness and spe preference. The C occasionally get up identified R9 requir with dressing, groof refused to get out ob ingo or a bath.  R9's care plan date self care deficit rela related to history of weakness and para indicated R9 staye dresses daily. The required assist of of hair daily. The care required assist of of per day with hair w resident would get The care plan did r of hair care or iden minimize/reduce ref On 09/29/2014, at be lying in bed. He unclean.  On 9/30/14, at 1:18 bed. Her hair was On 10/01/2014, at	aily living (ADL)/Functional ment (CAA) dated 12/2/13, hemiplegia and overall inther days in bed per her AA indicated R9 would of for bingo. The CAA also red maximum to total assist oming and bathing and R9 of bed except occasionally for ed 9/2/14, identified R9 had a lated to grooming and bathing f stroke with left sided alysis. The care plan also d in bed and wore house care plan directed staff R9 one with grooming, and comb e plan further directed staff R9 one with partial bathing twice lash in bed weekly, or if up hair wash in beauty shop. not identify R9's routine refusal latify interventions to	F2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	On 10/1/14, at 7:5 a bed bath. She son 9/30/14, but did washed.  On 10/01/2014, at stated R9 usually rwashed. NA-B ind mess it caused to rindicated R9 had recap shampoo or drwould sometimes at the beauty shop wh NA-D stated R9 woweeks without was R9 liked to have he her hair to be wash On 10/01/2014, at reapproached R9 at Confirmed R9's hair RN-A stated R9 was preferences and ne such care.  On 10/02/2014 at 8 confirmed the refusives not on R9's cathave been.  On 10/02/2014, at like to have her hair to have her hair the mess it created her hair washed at	5 a.m. R9 stated she receives stated she received a bed bath not know if her hair had been 9:42 a.m. NA-B and NA-D efused to have her hair icated R9 does not like the wash her hair in bed. NA-D efused alternatives such as my shampoo. NA-B stated R9 allow her hair to be washed in hen she got up. NA-B and build frequently go longer than 2 hing her hair. Both indicated er hair colored and would allow	F 2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	483.20(k)(3)(ii) SERPERSONS/PER CATTHE SERVICES Provided to accordance with eacare.  This REQUIREMENT of 1 resident (R19 wanderguard, and for timely positioning. Findings include: R19's care plan day wore a wanderguard unknowingly leaving.  On 9/30/14, at 9:05 to find the wanderguard of the wanderguard of the wanderguard unknowingly leaving. On 10/1/14, at 7:55 to have the wanderguard on the wanderguard on wearing one.  On 10/1/14, at 8:53	or get up and get it done. RVICES BY QUALIFIED ARE PLAN  ded or arranged by the facility by qualified persons in arch resident's written plan of  NT is not met as evidenced  tion, interview and document ailed to follow the care plan for each of 1 resident (R4) reviewed and incontinence care.  ted 6/30/14, indicated R19 and to prevent injury from	F 2		Element 1 Residents R4 and R19 have been reassessed and their care plans have been updated as appropriate for repositioning, continence care, and wander guard use. The care plans have been implemented and communicated the NARs via POC (point of care) kithroughout the facility.  Element 2 A base line audit was performed on residents who need repositioning, continence care, and/or are at risk felopement. Care plans were update appropriate. The care plans have be implemented and communicated via kiosks located throughout the facility.  Element 3 Accountability, communication and implementation of resident care plan interventions have been communicated via POC kiosks/paper documents a have been educated to nursing staff	ve have ted to iosks  all for ed as been a POC y.  n ated ind	11/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	to be turned and rewhen up in her when every two hours.  On 10/1/14, at 7:05 at the dining room to bathroom, and transonto the toilet at 9:2  On 10/1/2014, at 9: (NA)-H stated R4 was toileted since that to the stated R4 was toileted every 2 hours.  On 10/1/14, at 12:2 plan was not follow toileting.  The undated care printerdisciplinary teas implement a comprindividualized and of the resident.  483.25 PROVIDE CHIGHEST WELL BIEST WELL BIE	d 9/11/2014, indicated R4 was positioned every 1 1/2 hours led chair, and offered toileting a.m. R4 was observed sitting lable. R4 was wheeled to the sferred with a mechanical lift less a.m.  30 a.m. nursing assistant less placed in her wheel chair less placed in her wheel chair less of the repositioned or less to be repositioned and less.  0 p.m. RN-A verified the care led regarding repositioning and less less good to meet the needs of CARE/SERVICES FOR	F 28	Element 4 20% of resident care plan intervity will be monitored by the DON of for implementation daily x 7 day weekly x 4 weeks, then monthly month, and thereafter quarterly. Variances will be reported to the Administrator for immediate foll reviewed at QAPI at least quart	designee rs, then for 1	11/12/14

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING		10/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 APPROPR DEFICIENCY)	BE COMPLÉTION	
F 309	by: Based on observareview, the facility of comprehensive assimplement interver chronic pain for 3 of reviewed who expealleviate pain result and R11. In addition wheelchair position who had improper  Findings include: R25 was experient on a regular basis medications and with pain. In addition interventions were alleviate pain. R25's significant chindicated R25 was understood others, self-understood an and wants both verification. R15's significant chindicated R25 was understood others, self-understood an and wants both verification. The MDS ascheduled pain medicated pai	NT is not met as evidenced tion, interview and document	F 309	,	were  ress meet R31 that was cility nented ding ogic hairs g. eflect e to d oain more n was	
	MDS identified diag	gnoses including: rheumatoid ain syndrome, osteoporosis, ease and transient ischemic		positioning.  Element 4  All residents will be evaluated for panursing staff at least every shift on or	ain by	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245428	B. WING		10/0	10/03/2014		
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 309	indicated R25 had  R25's care plan las rated her pain on a (PRN) medications Interventions indica ambulation and exother pharmalogica addressed.  The 6/12/2014, Pa summary indicated Fentanyl (narcotic micrograms (mcg) every 72 hours and medication to treat milligrams (mg) Prof 5 days. The asshad pain related to R25 participated in toilet and also ambassessment indica was adequate for pshould continue cut.  The 6/25/14, thera was doing very we varied due to pain neck from arthritis continuation of am.  The 8/12/14, physistarted on oxycodo tablet every four hor the 9/2/2014, physistarted yellows.	arthritis and pain varied.  St revised 8/5/14, indicated R25 a scale of 1-10 and as needed amay be given if indicated. Atted R25 was to participate in ercises to decrease pain. No all interventions were  in Data Collection Assessment I R25 utilized a scheduled medication) patch 25 which was to be changed at Percocet 5/325 (narcotic moderate to severe pain) RN which was taken daily 4 out essment further indicated R25 childhood rheumatoid arthritis, activities, ambulated to the bulated with staff. The ted the medication regimen pain management and that staff rrent care plan.  Py progress note indicated R25 Il although ambulation distance in her legs, back, hands and pain and directed the bulation as tolerated.  Cian order indicated R25 was one (Percocet) 5/325 mg. one	F 309	DON or designee will monit MARs for excessive PRN us moderate to severe pain lev weeks, then monthly for 2 m thereafter quarterly. DON of monitor all residents in whe appropriate positioning daily then weekly x 3 weeks, ther months and thereafter quart Variances will be reported to Administrator for immediate reviewed at QAPI at least quart variances.	se and vels weekly x 4 nonths, and or designee will el chairs for v x 7 days, n monthly x 2 terly. to the follow up and			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/	03/2014	
	PROVIDER OR SUPPLIER	N & LIVING CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309	(previously 25 mcg) hours for 30 days. administration reco and assessment of R25's Fentanyl pate. The 9/15/14, physic her legs hurt and in peripheral edema be long time. The note little worse and mornote also indicated rheumatoid arthritis indicated R25 had at that the elevation of the edema, and symptomatic for he (basic metabolic particular one on Friday and second of the edema, and symptomatic for he (basic metabolic particular) and symptomatic for he (basic metabolic particular). The 9/24/14, nurse practical nurse (LPI complained of sever (evening), and that been given at 4:40 minimal relief after note indicated the roas very swollen, for lacked documentate 2nd dose of the PR. The 10/2/2014, phy R25's current medicated to tre 25/ml (milliliters) injustic every 72 hours.	and to change every 72 The electronic medication rd (EMAR) lacked monitoring the efficacy of the increase in ch.  cian note indicated R25 stated dicated R25 had 2 plus dilaterally which she'd had for a minimizer indicated the edema was a re uncomfortable for her. The R25 had severe deforming The physician's plan not previously utilized diuretics, f her legs was not taking care	F3	809				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Percocet 5/325 mg acetaminophen 329 hours for minor or between scheduled not exceed 3000 m hours.  The EMAR dated 9 following:  -R25's PRN Percoco on average of 3 tim times in one day, wadministered.  -PRN Percocet was lower extremity discover extremity discov	1 tablet every 4 hours PRN, 5 mg two tablets PRN every 4 breakthrough pain and give 1 Percocet doses if needed. Do 1g [acetaminophen] total in 24 1/2/14-10/2/14 revealed the 1/2/14-10/2/14 revealed the 1/2/14-10/2/14 revealed the 1/2/14 at 10 at	F	809			
	her legs hurt, "they them." At that time	are hard as a rock, just feel R25 removed her covers and or her legs that appeared shiny					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	and firm to the touch At 7:45 a.m. nursin observed assisting stated her groin/croso tight. At 7:50 a.m transferred from took knees hurt." NA-D: NA-D handed her astarted to put on the assistance. R25 stapants were too tigh pair of pants due to moaned in discomfeach pair of pants. R25 added, "Oh it htime (8:00 a.m.) R25 hat morning she no because of her leg observed to notify the dining room.  On 10/1/14, at 8:27 Percocet 5/325 mg at an 8.  At 8:50 a.m. R25 his breakfast and at 9: pain pill. LPN-A staminutes ago and R pain pill a while to wher breakfast.  At 11:25 a.m. NA-D in her legs. NA-D in her legs. NA-D is		F3	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	this morning for about "They [her legs] hur "They [her legs] hur At 1:05 p.m. R25 to (DON) her legs hur PRN Percocet 5/32 legs, rating the pair On 10/1/14, at 1:07 tell if R25's pain pill don't ask R25 if the because that was "another pain pill." It to ask for another pain pill before gett "It has been very or stated R25 did not acetaminophen for due to the staff did recommended amore Percocet also has a On 10/2/14, at 9:30 doing terrible with helgs. LPN-B stated to help. LPN-B stated to help. LPN-B stated pain and did not known as the staff and the pain pill before getter "It has been very or stated R25 did not acetaminophen for due to the staff did recommended amore percocet also has a state of the process of the p	stated,"[the pain pills] helped out two hours." R25 added, rt, they hurt, they hurt!"  In the director of nursing to the At 1:07 p.m. LPN-A gave to the sound to the director of nursing to the At 1:07 p.m. LPN-A gave to the sound to the director of nursing to the the the sound to the pain in her the at a 9.  In p.m. LPN-A stated staff can so were effective or not, staff to the planting in her the need for LPN-A stated staff wait for her to the pain pill. LPN-A stated NA-D that R25's legs hurt on the the LPN-A stated NA-D should the property around here." LPN-A added, the property around here. LPN-A receive the PRN to the property broader the probably not want R25 to exceed the point of 3000 mg, since accetaminophen.  In a.m. LPN-B stated R25 was the pain management for her the medications did not seem the did not been giving aminophen for break through ow why they did not give it.	F3	309			
		a.m. registered nurse (RN)-B d have contacted LPN-A					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/	03/2014	
	PROVIDER OR SUPPLIER  EAD REHABILITATION	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE IS 10TH AVENUE NORTHEAST EER RIVER, MN 56636	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309	regarding R25's pacares. RN-B verifie 2-3 times a day and given on a regular aphysician would be break through PRN given as directed by the staff could be depain on a daily basic current pain medicates were reporting that managed, the information to the DON.  On 10/2/14, at 11:2 PRN Percocet usuabut then R25 would LPN-B stated last in Percocet around 2: R25 was asking for however, did not git LPN-B stated due to bumped up dose of concerned about he she did get up by homogeneous through PRN implemented as directed on 10/2/14, at 1:5 consultant were into break through PRN implemented as directed on 10/2/14, at 2:30 surveyor with a phy indicating R25 was hips, make appoint resident qualified for was worse than riging 2 tabs by mouth thrested on the staff of the sta	in and before starting a.m. d R25 had used PRN Percocet d she questioned if it should be basis. RN-B stated the contacted and verified the acetaminophen should be y the physician. RN-B stated oing some monitoring of R25's s for the effectiveness of her ations. RN-B added if staff R25's pain was terribly mation needed to be relayed  O a.m. LPN-B stated R25's ally was effective for a while state, "Old Arthur hurts." hight LPN-D gave R25 a PRN OO a.m. and then 2 hours later another pain medication, we her anything. O the fact R25 was on the Duragesic patch, staff were er being a fall risk because	F3	809				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATIO	N & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST EER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	which affected her a of daily living, withouthe pain and/or efficient medication. In additinterventions were alleviate pain.  R6's annual MDS dintact cognition and assistance for all additional assistance for all additional assessment period level at a 5 on a 0 to assessment indicate to participate in day.  R6's Pain CAA date voiced complaints of scheduled pain memedication for breat attributed to cerebrate muscle spasms. The assisted her to take throughout the day informed of the pair.  R6's quarterly MDS R6 had intact cognitional assistance with all additional and intact cognitional and intact	ag chronic pain on daily basis ability to participate in activities ut adequate assessment of cacy of the narcotic cion, non-pharmacological not implemented to help atted 3/3/14, indicated R6 had required extensive staff ctivities of daily living. The during the annual R6 had reported her pain to 10 pain scale. The ed the pain limited R6's ability	F3	609			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa assessment period be at a 6 on a 0-10	I, R6 had reported her pain to	F 30	9			
	alteration in comfo in the hands secon and muscle spastic palsy. The plan din needs and respond plan did not direct potential leg pain a	ed 6/4/14, identified an rt related to numbness/tingling idary to carpal tunnel syndrome city secondary to cerebral rected staff to anticipate her d in a timely manner. The care staff on how to minimize and it did not include cal interventions to minimize					
	biggest problem we note also indicated the clock and askir medications. The presentance for to monitor for pain the pain medication	e dated 7/3/14, indicated R6's as related to pain control. The lat that time, R6 was watching ng for frequent pain ohysician had initiated use of a R6 and indicated the staff were control and anxiety related to ns. The physician identified a make pain medication is not effective.					
	and 8/12/14, for a progress notes did a visit on 9/5/14, tl	e physician on 8/5/14, 8/8/14 n acute infection, those not address R6's pain. During he physician noted, "Will current pain medications, which well for her."					
	included Baclofen times a day, Gaba treat nerve pain) 30 Tylenol extra stren	er Report dated 9/5/14, (muscle relaxer) 10 mg three spentin (medication used to 00 mg three times a day, and gth 500 mg one tablet every led for pain. In addition, on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245428	B. WING		10/	03/2014		
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	, , , ,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 309 Continued From page 21		age 21 an had added Fentanyl	F 309	9				
		atch) 25 mcg/ hour to be						
	R6 on 8/30/14 - 9/3 3/31/14, and 11/27, collection tools indidaily. After each pregistered nurse control of the summary repermedications, indications, indication	ted a Pain Data Collection for 8/14, 5/31/14 - 6/4/14, 2/27/14 - 7/13 - 12/1/13. The data cated R6 experienced pain ain data collection period the empleted a review of R6's pain. ated the current pain ated R6 had voiced concerns of cted staff to assist with comfort medications, repositioning, hysical therapy interventions. maries did not address R6's rrent medication regimens. In all record lacked indication of the Fentanyl patch started active.						
		lent progress notes (nurse's e following information:						
	pain more frequent on Tylenol prn whice p.m. and 11:23 p.m. and request pain p minutes) throughout repositioned with re- before she would re-	.m. R6 was complaining of thy this shift. She is currently the she had received at 6:00 n. R6 continued to holler out ill frequently (every 15 ut the night shift. R6 was elief lasting 15-30 minutes equest additional medications. m. R6 received Tylenol 500						
		complains of pain responds g and massage as						
	- 7/31/14, at 2:57 a	.m. R6 had Tylenol 500 mg at						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10	/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 22	F 30	9		
	1:30 a.m. Non-pha	armacological interventions nt was due for PRN included osition and range of motion				
	-8/17/14, at 5:11 a.m. R6 requested Tylenol one time. No further follow up was noted.					
- 8/28/14, at 6:41 a.m. R6 receiv mg for leg pain. The note lacked pain.		•				
	in a wheelchair in t cry with tears runni staff. She stated, " were observed in the holding her head. walked up to R6 ar	D a.m. R6 was observed seated he dining room. R6 began to ing down her face calling out to 'Oh, oh oh." No staff members he dining room as R6 cried A few moments later NA-A and escorted her to her room. as observed resting in bed.				
	in a wheelchair in t cry, "Ey, ey, ey, oh looking for staff me	D a.m. R6 was observed seated he dining room. R6 began to that leg." R6 turned her head embers and began to cry "oh she shook her head.				
	At 9:05 a.m. NA-A	wheeled R6 to her room.				
	every day. She sta sitting in her wheel received pain medi but she often has t next medication. S	stated R6 cried out in pain ated R6 would complain while chair. NA-A reported R6 ications for pain management o wait until it is time for the She stated R6 frequently in her room waiting for the next				
	On 10/2/14, at 9:45	a.m. R6 stated she				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/	03/2014	
	PROVIDER OR SUPPLIER  EAD REHABILITATION	ON & LIVING CENTER		115	EET ADDRESS, CITY, STATE, ZIP CODE  10TH AVENUE NORTHEAST  ER RIVER, MN 56636	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	experienced pain in ask for Tylenol. She care of the pain for the pain in her left I often had to watch dose of pain medic as a "toothache tha stated the pain premany of the activities sometimes it was better at an 8 or 9 on a 0-she has to watch threceiving her pain in Stated she attempts her leg, but it usual relief. She stated Fof pain relief, but it the pain to the nurs Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:  7/1/14 - 7/31/14, Reproduction Review of the EMA information:	her left leg every day and will explained the Tylenol takes about an hour. R6 explained eg woke her at night and she the clock to wait for her next ation. R6 described the pain at never goes away." She wented her from participating in the facility because wetter in the chair and other in bed. R6 described the pain 10 pain scale daily. R6 stated the clock to make sure she is medications.  To a.m. NA-D stated R6 ther left leg every day. She is to reposition R6 in bed or rub ly does not give R6 extended R6 may have a few moments did not last long. She reports	F3	.09				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa PRN Tylenol 500 m	_	F 309			
		ented for the medication was  The medication was noted to pmewhat effective."				
	reported complaints stated R6 will request watch the clock was before she can ask R6 was uncomforta something to giver when she would acmedications she fo	0 a.m. LPN-B stated R6 s of pain "all of the time." She est pain medications and will iting for the four hours to pass for the next pill. LPN-B stated able, "I wish we could find her relief." LPN-B stated dminister R6's pain llowed up with R6 by visually e stated if the nurse were to				
	ask her how her pa more medications. she was not in pair	LPN-B added if R6 looked like n, they write effective or e. She confirmed she did not				
	with the interim DO interim DON stated pain daily. The two record and were ur the staff had complassessment of R6's determine if the Fe	00 a.m. R6's pain was reviewed N and the consultant RN. The I she was aware R6 expressed of RNs reviewed R6's clinical hable to find indication in which leted a comprehensive is pain and were unable to ntanyl which had been added effective medication for .				
	confirmed R6 expe been comprehension to determine the ex	20 a.m. the consultant RN rienced pain daily and had not vely reassessed by the nurses stent of the pain. She stated exhausted resources to reduce				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	received non-pharm minimize pain and She stated she was medications for the aware she was utili per month. At that asked to review R6 determine a timelin in the past 6 month	offirmed R6 had not consistently macological interventions to she continued to express pain. It is aware R6 was utilizing PRN to treatment of pain but was not sizing over 70 PRN medications to time the RN consultant was C's medication regimen to the of pain medication changes	F3	809			
	she had interviewe expressed continue not find it helpful to determine what had but felt it was bette forward and treat F provided a Patient	d R6 and confirmed R6 ed pain. She stated she did review R6's record to d been attempted in the past, r to take the time and move R6's pain. The consultant RN Comfort Assessment Guide ch confirmed R6 continued to					
	chronic pain on dai ability to participate without adequate a efficacy of the narc implementation of	cing moderate to severe filly basis which affected her in activities of daily living assessment of the pain and / or cotic medication nor consistent non-pharmacological p alleviate the pain.					
	included osteoporo become fragile and leg osteoarthritis (o the cartilage), chro	icated R11 had diagnoses that usis (a disease in which bones if more likely to fracture), lower degenerative arthritis affecting nic pain, restless leg syndrome anulomatosis (causes					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/0	03/2014
HOMESTEAD REHABILITATION & LIVING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636		10/00/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	indicated R11 had and required exten locomotion on and personal hygiene a staff for bed mobili and corridor and to indicated R11 rece pain medication and for pain. The MDS her pain as modera interfere with daily sleep at night. The received physical to therapy (OT) service of motion (ROM) received physical to the repain as moderate cognimited assistance transfers, dressing of one staff for amble locomotion on and hygiene. The MDS scheduled and as a non-medication introduced R11 and frequent but it activities or make in MDS indicated R11 restorative nursing R11's pain CAA daremained at risk for pain and unrelieved effects of chronic of R11 reported pain	nange MDS dated 8/11/14, severe cognitive impairment sive assistance of one staff for off the unit, dressing and and limited assistance of one ty, transfer, ambulating in room silet use. The MDS also ived scheduled and as needed and non-medication interventions also indicated R11 reported ate and frequent but it did not activities or make it difficult to a MDS further indicated R11 herapy (PT) and occupational des and received active range estorative nursing services.  2S dated 7/12/14, indicated R11 nitive impairment and required of one staff for bed mobility, and toilet use and supervision coulating in room or corridor, off the unit, and personal also indicted R11 received needed pain medications and erventions for pain. The MDS reported her pain as moderate did not interfere with daily the difficult to sleep at night. The ladid not receive PT, OT or	F3	809			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE IS 10TH AVENUE NORTHEAST EER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	remained alert and effectively and apprif and when in paint to observe and repepain. Finally, the CAchronic in nature ar PRN analgesics to  R11's Activities of ERehabilitation CAAremained at risk for to progression of chresulting in a past hand functional urina indicated R11 had rhospitalization for pwas to continue to a needed and report tolerance. The CAA on going fluctuation tolerance based on chronic disease processing a verbal scale of pain medication. Tadminister medicate monitor for effective possible side effect identify or address	able to communicate needs repriately and could alert staff. The CAA indicated staff was port any non verbal indicators of AA indicated R11's pain was not required scheduled and maintain optimal comfort level.  Daily Living / Functional dated 8/23/14, indicated R11 further on going decline due pronic disease processes history of falls, chronic pain ary incontinence. The CAA returned to baseline since processes with ADL and mobility as changes in ability and a also indicated anticipation of a of physical function and potential exacerbation of	F3	809			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING		<del></del>	10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309		edical record revealed the garding the ongoing	F3	309			
	the Pain Data Coll 1/12/14, indicated assessment period Lortab (hydrocodo pain reliever for mmg three times da anesthetic) to lower R11 could also have breakthrough pain any during the ass Non-medication in repositioning, exervisits. R11's pain to assess the R11's pain to a second pain and the R11 could also have breakthrough pain any during the assessment and the R11 could also have breakthrough pain any during the assessment and the R11 could be a second pain as a second pain and the R11 could be a	though she had not received					
	identified R11 had pain with weight be identified R11 had disease and R11 h previous that had progress note furth	gress note dated 2/25/14, a chief complaint of right knee earing for 1 week. It also a history of degenerative joint and last had an injection months nelped "for a long time." The ner indicated R11 received a to her right knee at the visit.					
	indicated the visit knee pain and ider of that pain with th very long. R11 coweight bearing and	gress note dated 3/10/14, was for follow up on R11's right ntified R11 reported some relief e cortisone injection but not for ntinued to report pain with d stated it hurt even while in progress note also identified					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	` '	E SURVEY MPLETED
		245428	B. WING _		10/	/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	PRN basis. R11 refor a while but work assessment identification degenerative joint of cortical steroid injerelated to activity a progress note idento increase R11's la Fentanyl patch from 12.5 micrograms (rher current dose of hydrocodone.  The physician's teleincluded the following Norco (hydrocodone)  The physician's teleincluded the following reliever for more pain 15-325 mg one as needed, trial of change every 3 day Lortab.  The RN Assessmenthe Pain Data Colle R11 had reported plook back period as scheduled pain memedication frequents summary also indicated and be a this time a knee bradiscontinued due of further identified R1	age 29 ag Lortab on a scheduled and eported the medication worked off. The physician ied right knee pain with disease, transient response to ction with constipation likely and pain medications. The tified the physician's plan was exatives and switch her to a an scheduled hydrocodone, ance) per hours equivalent to an action of 30-40 mg per day of a scheduled hydrocodone, ance) per hours equivalent to a scheduled hydrocodone, and per day of a scheduled hydrocodone, and per day of a scheduled hydrocodone, and per day of a scheduled hydrocodone, and a scheduled hyd	F 30	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER EAD REHABILITATION	ON & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	R11 was needing to times a day nearly of pain. The memore often the given more often the physician responder for Norco three twice a day PRN for the Memore to Physical R11 appeared to be and questioned contract they could consider of Vicodin (hydrocomorphine versus For R11's family had converted the physicial (time-released more twelve hours for chief R11's Norco back to and twice a day as	sician dated 4/18/14, identified to take her PRN Norco three each day and still complained to asked if the medication could in for R11's breakthrough pain. Onse dated 4/21/14, was an et times per day with Norco in breakthrough pain.  Sician dated 6/1/14, identified et more drowsy and lethargic infusion. The memo asked if it going back to increased dose done-acetaminophen) or oral entanyl. The memo indicated enterns with Fentanyl and ento consider MS Contin phine usually taken every ronic pain) and an increase of to 10-325 [sic] four times a day needed. The physician 2/14, indicated "we'll see how	F3	809			
	R11 was seen for bindicated mood wis dysphoria. R11 was vision and hearing identified R11 was that was helping. Thad been some conconfusion and there about switching back.	Note dated 6/12/14, identified illateral hearing loss and e R11 still had some s not sure if this was related to issues or just mood. The note on 12.5 mg per day of Zoloft the note also identified there incern about increasing e had been some discussion ock from Fentanyl to Norco. entified R11 had only taken 3 wast 2 weeks while on the					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Fentanyl. The physiconcern for intermine would hold off of time. The impression	sician's impression was some ttent confusion and indicated in the Fentanyl change at that ion also indicated a possible be physician increased her	F:	309			
	R11's family was vestatus might be relaspecifically Fentany indicated he felt R were possibly relaterelated to her vision physician's plan warestless leg syndrotwice a day and hophysician indicated the road if R11 did Other options identifications.	Note dated 7/8/14, indicated ery concerned her decline in ated to medications, yl. The physician impression 11's mental status changes ed to depression and likely and hearing loss. The as to lower gabapentin (for me) from four times a day to ld R11's Fentanyl. The morphine was an option down well off of the hydrocodone. ified were discontinuation of her or increase or decrease of					
	included decrease	lephone Orders dated 7/8/14, gabapentin to 300 mg twice anyl patch trial for one week.					
	the Pain Data Colle -7/12/14, identified daily and indicated balance pain contro The RN repeated the regimen and indication work with the physical	nt Summary dated 7/14/14, on ection form dated 7/8/14 R11 reported moderate pain the physician was trying to ol and symptoms of confusion. The current pain medication ted they would continue to cian for pain control. The tidentify non-pharmacological					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST EER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY 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 APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From p interventions for p	- <del>-</del>	F 3	609			
		elephone Orders dated 7/15/14, apentin and discontinued					
	R11 was seen reg to pain, delirium, h physician's impres vertebral compres The physician's pl wondering about r indicated he was of for their advice. H would not change	e Note dated 7/29/14, indicated arding family concerns related nearing and intake issues. The ssion included pain issues with sion fractures and arthritis. an identified R11's family was morphine. The physician considering a referral to hospice lis plan further indicated he medications until R11's th (identified upon physician evaluated.					
	R11 was hospitaliz 8/4/14 for pneumo	zed from 7/31/14, through onia.					
	R11 on 8/5/14 - 8/ summary of the da 8/13/14, identified during the assess the current pain m indicated R11's pa current regimen w assessment summ	eted Pain Data Collection for 9/14. The RN assessment ata collection completed on R11 had complained of pain ment period. The RN repeated redication regimen and ain was rated as mild and the ras meeting R11's needs. The mary did not address ical interventions for pain.					

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING		10	/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	adhesive patch 5% topically to mid-back hours for chronic putimes a day (scheot tab twice a day PR 500 mg 1 tab every report also include right knee for commof 10 minutes with The Nursing Home R11 was seen by the knee pain. R11 re The nurse practition	age 33 cluded orders for Lidoderm of mg/patch), apply 1 new patch ock daily on 12 hours and off 12 rain, Norco 5-325 mg three duled dose), Norco 5-325 mg 1 N for pain, and acetaminophen of 6 hours PRN for pain. The of an order for heat or ice to fort as needed on for intervals a start date of 3/17/14.  The Note dated 10/1/14, indicated the nurse practitioner for right ported discomfort with walking. The plan was to apply ice or ice, continue with pain	F 309			
	medications on the administration reco as tolerate.  R11's Medication A 8/8/14 -10/3/14 rev -Lidoderm adhe administered early daysNorco 5-325 m dose) was given ea 8/25, 9/12, 9/22, 9/10/2, and 10/3 and (11 doses).  R11's PRN Medica 8/8/14-10/3/14 rev -Norco 5-325 m doses were given of pain in knees or	e MAR (medication ord) and participate in activities administration History dated realed: esive patch 5% was at R11's request 30 of 57 ag three times a day (scheduled arly for the morning dose on 25, 9/26, 9/29, 9/30, 10/1, I for the afternoon dose on 9/9 attions Administration History				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10	/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	9:42 a.m. and 2:29	given between the hours of p.m. and 3 doses were given	F 30	9		
	The medications w somewhat effective 9/28 which was as R11's next schedu earlyacetaminopher as needed was give and given three times	of 11:01 p.m. and 11:31 p.m. were assessed to be effective or except for one dose given on sessed to be not effective and led dose of Norco was given in 500 mg 1 tab every 6 hours were once on 8/8, 8/30, and 9/3 mes on 10/2 for complaints of gs. The medications were ective				
	8/8/14-10/3/14 revi -Heat or ice to righ for intervals of 10 r	dministration History ealed: t knee for comfort as needed minutes was not documented ecord during this time period.				
	11:23 p.m. indicate R11's right knee tw	ess note dated 10/1/14, at ed an ice pack was applied to to times during the shift. R11 ter" however, within 1-2 hours akthrough pain.				
	her room seated in had been having a knee and raised he began to rub it. Th swollen. R11 state the knee pain and "but they don't last 10/1/14, she was g	4 a.m. R11 was observed in a recliner. R11 stated she lot of problems with her right er pant leg above her knee and he knee was observed to be at she was given pain pills for that they lasted a little while forever." She stated that on given cold packs, as well, and the bit. R11 stated the pain				

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CENTER		STREET ADDRESS, CITY, 115 10TH AVENUE NOR DEER RIVER, MN 56	THEAST	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD ICED TO THE APPROPI EFICIENCY)	BE	(X5) COMPLETION DATE
F 309	kept her up at night night she was "up a pill. R11 stated the about 4 hours befor again. R11 also state couple of times a dath at time at an 8 our received cortisone at they lasted for about came back. R11 further bath today and on her knee.  On 10/02/2014, at 3 ambulating down the from her room to the slow and R11 was observed. R11 was observed R11 stated her knee whirlpool bath.  On 10/2/14, at 10:4 seated in her room walker in front of helimited her activities her from joining in. R11 stated her knee a 7 out of 10 on a 1 her knee hurt all the	at times and that the previous a lot" until she finally got a pain pain medication lasted for re her knee began hurting ted she asks for a pain pill a ay and identified her pain at t of 10. R11 stated she also shots from the physician and at a month but the pain always rther stated she was due for the whirlpool tub also felt good et hall with wheeled walker e bath room. Her gait was observed to favor her right leg. The felt much better after her as a.m. R11 was observed ward her room after her bath. To be limping on her right leg. The felt much better after her as a.m. R11 was observed in a recliner with a wheeled er chair. R11 stated the pain a during the day and prevented She stated, "I just can't do it." The currently still ached and was to 10 pain scale. R11 stated the pain scale. R11 stated the but it was alright if she to the R11 further indicated.	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10	/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	had pain daily and since recently burn indicated R11 would felt up to it and att nursing] three time her right knee both then did not do ex.  On 10/02/2014, at had pain every day for the pain. NA-E of any non-pharmarelief of R11's pair that aggravated R spent most of her out for meals or a family used to brint to visit and have c did this when they R11's pain was most of the rest and had not refused exercises to both NA-C confirmed R Review of the rest August 2014, and had not refused exertemity.  On 10/02/2014, at 11 worked with R11 we exercise to both NA-C confirmed R Review of the rest August 2014, and had not refused exertemity.	10:48 a.m. NA-B stated R11 may have had more pain lately ping her right knee. NA-B and go to some activities if she ended therapy [restorative as a week and would tell them if hered her too much so they ercises on that leg.  10:55 a.m. NA-D stated R11 and received pain medication of indicated she was not aware acological interventions for the nor was she aware of factors 11's pain. NA-D stated R11 time in her room and only came bath. NA-D also stated R11's g her out to the common area offee, however they no longer visited. NA-D further indicated ostly in her knees.  105 a.m. NA-C stated she with restorative nursing upper and lower extremities. 11 had pain in her right knee. Orative nursing sheets for September 2014, revealed R11 tercises to the right lower	F 30	9		
	medication three t	d R11 received scheduled pain imes a day and could also have ion for her knee pain. She				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		115	EET ADDRESS, CITY, STATE, ZIP CODE  10TH AVENUE NORTHEAST  ER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	was usually needed occasionally given of PRN Norco was us did not specifically a medication was or a using the 1-10 pain given. LPN-B state resident about pain them to ask for add stated instead she effectiveness or har R11 and see if she LPN-B indicated R2 her legs before but very occasionally as since the warm pace indicated that the wand R11 had liked to the past. When as warm or cold packs stated "sometimes indicated that curre in pain and had just instructed her to eleuntil the medication stated R11 stayed incame out occasional on 10/02/2014, at a consultant RN confinave been used as intervention for R11 should have been resident passeline functional	for extra pain medication, it don the night shift but was during the day. LPN-B stated ually given. LPN-B stated she ask R11 how effective the pain asked R11 to rate her pain scale after medication was a medication would prompt litional medication. LPN-B would simply observe for we general conversation with complained of further pain. It had used warm packs on stated they had only done so not it had been about a month eks had been used. LPN-B warm packs had been effective the warm packs when used in ked why they stopped used for R11's knee pain, LPN-B you get complacent". LPN-B ntly if R11 indicated she was thad a pain pill, they evate her legs and take it easy worked. Additionally, LPN-B n her room quite a bit, but	F3	09			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	age 38	F 30	9			
	dated 10/3/14 which	Comfort Assessment Guide the confirmed R11 continued to spain that only went away with					
	directed staff to as and provide optima control plan which the resident, family team. The policy of resident's pain, de- pharmacological in	ed Pain Assessment Policy, sess the resident's pain level al comfort through a pain was mutually established with and members of the health directed the staff to assess the velop pharmacological and non atterventions to reduce the pain physician of any unrelieved					
	R31 was not provide to ensure appropri	ded leg rests on the wheelchair ate positioning.					
	R31 was cognitive wheelchair locomo non-ambulatory. R indicated R31 had foot, was non- weight	IDS dated 8/23/14, indicated ly intact, was independent with tion, transferring and was 31's Fall CAA dated 8/23/14, a puncture wound on her left ght bearing and could safely he bed to the wheelchair and					
	her wheelchair self R31's feet were ob about eight inches	p.m. R31 was observed in forppelling with her hands. served dangling unsupported from the floor. There were not on the wheelchair.					
	On 9/30/14, at 8:46 provide her with wl	6 a.m. R31 stated they did not neelchair leg rests.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245428	B. WING		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	her wheelchair with in a walking boot a eight inches from the seight inches from the seight inches from the was able to use he walking boot to he her right foot were. The wheelchair was at a table playing a remained unsupposite inches from the flow on 10/1/14, at 8:10 her wheelchair. R3 her left foot dressing R31's feet were obtained and inches from the inches from the flow on the flow of the seight foot dressing R31's feet were obtained and inches from the inches from the flow of the seight foot dressing R31's feet were obtained and inches from the flow of the seight foot dressing R31's feet were obtained and inches from the flow of the seight foot dressing R31's feet were obtained and inches from the flow of the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were obtained and inches from the seight foot dressing R31's feet were dressing R31's feet were dressing R31's feet were dressing R31's feet were dressing R31's feet we	was observed self propelling he her hands. Her left foot was and her right foot was about the floor.  was observed self propelling elchair back to her room. R31 er left foot that was in the lp with propelling. R31's toes of observed to touch the floor. as not equipped with leg rests.  was observed in her wheelchair a game. Her right heel orted and dangling about eight		,			
	was admitted in a neither physical the therapy (OT) had swas so independe wheelchair with he not noticed that R3 At 11:20 a.m. R31 had was equipped was too wide for he this time OT-A stated her fe	wheelchair. RN-A stated erapy (PT) or occupational seen R31. RN-A stated R31 nt with self propelling her rhands. RN-A stated she had 31's feet did not touch the floor. stated the first wheelchair she with leg rests and that chair er to get into the bathroom. At ted R31 was up "way too high." set were eight inches from the she only used her hands to					

				E SURVEY MPLETED		
		245428	B. WING _		10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	OT-A stated he wor adjustments for production of the control of th	angle from the wheelchair. All make wheelchair poer wheelchair positioning.  Stated since her first wide for her, family member urrent wheelchair in the her to use about two weeks  a.m. nursing assistant (NA)-C of see a resident that did not chair positioning she would atted she had not worked for a policy related to proper ing tent/SVCS TO RESSURE SORES  Are must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that	F 30	09		11/12/14
	pressure sores reciservices to promote prevent new sores  This REQUIREMED by: Based on observareview, the facility f	able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.  NT is not met as evidenced tion, interview and document ailed to ensure a resident pressure ulcers received		Element 1 A tissue tolerance was perform and the pressure ulcer prevent		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		SURVEY PLETED
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER  EAD REHABILITATION	ON & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	assistance with rep the development of resident (R4) in the Findings include: R4's diagnoses include: R4's diagnoses include: R4's diagnoses include: cerebral palsy, strothe electronic medited (EMAR). The quarterly Mining 9/6/2014, indicated required extensive mobility, transfers, MDS also indicated ulcers.  The 3/6/14, Pressu Assessment (CAA) for pressure ulcers non-ambulatory.  The care plan dated to be turned and rein bed and 1 1/2 hodue to risk for pressures.	ositioning in order to prevent pressure ulcers for 1 of 1 sample.  Juded a multiple sclerosis, ke, and diabetes, according to cation administration record num Data Set (MDS) dated R4 had cognitive impairment, assist from staff for bed and was non ambulatory. The IR4 was at risk for pressure	F3	314	,	mains n.  own air, and rance.  OC  was ted to  elchair, nitored uty t 2	
	assessment indicat ulcers due to immo On 10/1/14, at 7:05	en Tissue Tolerance red R4 was at risk for pressure bility and incontinence. a.m. R4 was observed sitting at the table. At 7:30 a.m. R4's					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		E SURVEY MPLETED
		245428	B. WING _		10	/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	son stated she had came to see her at 8:50 a.m., R4 was the table in the dinifinished her breakf; wheeled to the batt toilet. R4's skin to t intact with slight red  On 10/1/2014, at 9 surveyor, NA-H sta wheel chair at 6:30 repositioned or toile and 55 minutes wit stated R4 was to be every 2 hours.  On 10/1/14, at 12:2 (RN)-A verified R4 1/2 hours while in hear plan was not f 483.25(g)(2) NG TI RESTORE EATING  Based on the compresident, the facility  (1) A resident who alone or with assist tube unless the residemonstrates that unavoidable; and  (2) A resident who gastrostomy tube retreatment and service.	been up in the chair when he 6:45 a.m. From 7:50 a.m. to observed to continue sitting at ng room. At 8:50 a.m. R4 ast. At 9:25 a.m. R4 was broom and transferred to the he buttocks was observed dness.  30 a.m. when asked by ted R4 was placed in her a.m. and had not been eted since that time (2 hours hout repositioning). NA-H are repositioned and toileted  20 p.m. registered nurse was to be repositioned every 1 her wheel chair. Adding R4's ollowed.  REATMENT/SERVICES -	F 31			11/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING		10/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 322	ulcers and to restorable.	page 43 palities, and nasal-pharyngeal pore, if possible, normal eating	F 322			
	by: Based on observereview, the facility medications via gaindividually with ap 1 residents (R33) medications  Findings include: R33's Physician C 8/5/14-10/14/14 is post concussion secure (creation of an art stomach for nutrit compression).  During observation licensed practical aspirin 81 milligrar paper medication milliliters (ml) of la (gm)/30 ml into a then dispensed a 5-325 mg tablet in with the aspirin. F potassium chlorid (meq)/15 ml solution in the dispensed in the significance of the signifi	ation, interview, and document failed to administer astrostomy tube (G-tube) oppropriate water flushes for 1 of who received G-tube  Order Report dated dentified diagnoses that included syndrome and gastrostomy ificial external opening into the ional support or gastrointestinal on on 10/01/14, at 11:35 a.m. nurse (LPN)-A dispensed an m (mg) chewable tablet into a cup. She then measured 30 actulose solution 20 gram plastic medication cup. LPN-A hydrocodone-acetaminophen ato the paper medication cup. Tinally, LPN-A drew 4 ml of e 10% 20 milliequivalents ion into a 10 ml syringe. LPN-A blet medications into a plastic		Element 1 The nurse who did not flush the G-tu with water between individual medications and return demonstration was verified.  Element 2 All residents with G-tubes were asseduring medication pass for correct material per policy regarding flushing with water between individual medications.  Element 3 The policy regarding flushing with water between individual medications.  Element 3 The policy was reviewed and update appropriate. Licensed nurses were educated about the policy regarding flushing between individual medications when providing medications per G-tuber 4 The DON/designee will audit medicated administration according to policy for residents with G-tubes daily x 7 days weekly x 3 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the	ations policy en ssed pethod ter d as ons ube.	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	crushed medication and added 15 mls medications. LPN and gloves and endonned the gloves syringe. LPN-A structure the syringe and instilled air drew 30 mls of was flushed the G-tube the syringe and ins G-tube. LPN-A the syringe with the revia the G-tube. LF mls of water. Nex medication and was and instilled by deflushed the G-tube LPN-A squirted the syringe into the plainto the 60 ml syringe into the plainto the 60 ml syringe into the glove the syringe into the plainto the 60 ml syringe into the glove the glove the syringe into the glove the	d the medications, placed the ins into a plastic water glass, of warm water to dissolve the A gathered the medications itered R33's room. LPN-A and drew air into a 60 ml opped the tube feeding and ment of the G-tube by listening into the G-tube. LPN-A then iter into the 60 cc syringe and instilled 1/2 the solution into the endrew 10 ml of water into the maining lactulose and instilled instilled in into the G-tube with 15 the control of water. Next is potassium solution from 10 ml astic water glass and drew it inge, and instilled it into the interest into the G-tube with interest into the G-tube with interest into the grand instilled it into the interest into the G-tube with into the G-tube with interest into the G-tube with interest into the G-tube with into the G-tu	F3	322	Administrator for immediate follow userviewed at QAPI at least quarterly.		
	8/5/14-10/15/14 di 30 ml of water bef	rected staff to flush G-tube with ore and after each medication. direct the mixing of					
	pharmacy had told give oral medication	11:51 a.m. LPN-A stated that I them they could crush and ons together. LPN-A stated she ucted to give each medication nes between.					

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

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED		
		245428	B. WING		10/03/2014	
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 323 SS=D	registered nurse (R been instructed by between each med after a group of meno incompatibilities given concurrently.  On 10/03/2014, at confirmed the phys flush between each  The Enteral Tube N policy date 4/23/14 were not to be mixed was to be administration and clur to be flushed with a each medication to the medications.  483.25(h) FREE OHAZARDS/SUPER  The facility must energy in the medication and clur to the medication to the medications.	9:32 a.m. the consulting (N) indicated the facility had pharmacy to either flush ication or flush before and dications as long as there are between the medications  11:34 a.m. the consulting RN ician orders called for 30 ml medication.  Medication Administration directed crushed medications and together. Each medication ared separately to avoid mping. The enteral tubing was at least 5 ml of water between avoid physical interaction of	F 323		11/12/14	
	by: Based on observareview, the facility f	NT is not met as evidenced tion, interview, and document ailed to apply a wanderguard for 1 of 1 residents (R19)		Element 1 A wander guard was placed on residence R19 who is identified as an elopement		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	identified as wander unsupervised.  Findings include:  R19's annual Minimal 12/26/13, indicated impairment. The nawn 18/10/14, (late entry followed someone wanderguard alarm were checked and present. A new was result of the wanderguard wanderguar	mum Data Set (MDS) dated R19 had severe cognitive ursing progress notes dated for 8/9/14), noted R19 outside to the patio and her in did not sound. R19's ankles there was no wanderguard inderguard was placed.  Dowsheet for October 2014, read ON AT ALL TIMES MEMORY LOSS AND HIGH was no staff initial to indicate was being checked for illy basis. It indicated R19 rd to prevent injury from	F3	323	risk. Nurses are checking placement the wander guard every shift per the Element 2 A baseline audit of all residents who elopement risks were assessed for placement of wander guards. All residents wander guard placement being checked by nursing ever shift the MAR.  Element 3 The policy was reviewed and update appropriate. Nursing staff were ediregarding the policy and elopement precautions.  Element 4 The nurse on duty will assess all rewho are elopement risks for wander placement every shift per the MAR. DON/designee will monitor the MAR. documentation of placement of the wander guard weekly x 4 weeks, the monthly x 2 months and thereafter quarterly. Variances will be reported the Administrator for immediate foll and reviewed at QAPI at least quarkers.	e MAR.  o are  is t per  eed as ucated t risk  sidents r guard The R for en ed to ow up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING _		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	At 8:35 a.m. R19 ii the breakfast table At 9:15 a.m. regist R19 for a wanderg was not wearing or never had a brace director of nursing replaced a wander ago.	ndependently ambulated from	F 32	23			
	she only knew of the out into the pation and NA-A stated there someone would characteristic wanderguard was thought the wander At 8:53 a.m. RN-A followed regarding RN-A stated she would be a stated she wanderguard	ne one incident when R19 went and they were so surprised. use to be a system where neck weekly that the present. NA-A stated she rguard was on R19's ankle.  verified the care plan was not the use of the wanderguard. rould like to re-evaluate the use d. RN-A stated R19 did have not and was known to remove ard. RN-A stated they could an's orders for the wanderguard.					
	so the nurses wou every shift. RN-As front door and out weather and then work on 10/2/14, at 9:29 (LPN)-B stated she wanderguard for R stated in the cours wanderguard she I stated she would p	In Solders for the wanderguard and check for the wanderguard stated R19 would go out the to the patio to check the would come back in.  5 a.m. licensed practical nurse e was not checking the 19 daily. In addition, LPN-B e of R19 wearing the has cut it off 4-5 times. LPN-B probably check R19 for the nishe would go out the door					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCT  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245428	B. WING	·	10	0/03/2014
	PROVIDER OR SUPPLIER  EAD REHABILITATION	N & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 329 SS=D	and the alarm would outside to "sniff" the facility without redired residents who elope will be identified and designated on their Nursing staff would were listed on treated daily that the wanded 483.25(I) DRUG REUNNECESSARY DEACH TEACH TEA	d sound, and added R19 goes e air and comes back into the ection.  cy dated 10/2/14, indicated or have the potential to elope d have prevention plans individualized plan of care. ensure that wanderguards ment records and documented erguard was functioning. EGIMEN IS FREE FROM RUGS  g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any		329		11/12/14

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10/	03/2014	
	PROVIDER OR SUPPLIEI	₹ ION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 329	Continued From p	page 49	F 32	29			
	by: Based on observereview, the facility reduction for the used for insomnia residents (R14, Residents). Findings include: R14's Physician Odirected Paxil (and milligrams (mg) depression. The 7/3/2013. The cliredocumentation of since start date of lacked documentation of since start date of lacked documentations dialy.  R14's quarterly Meg/5/14, and the article dentified R14 as mood or behavior indicated R14 recomedications daily.  The Psychotropic Assessment date participated in act depression.  The care plan date	inimum Data Set (MDS) dated annual MDS dated 7/1014, being alert and oriented with no concerns. The assessment eived antidepressant  Medication Use Care Area d 7/10/14, indicated R14 ivities and did not show signs of ed 7/15/14, identified R14 as ressant medication for the		Element 1 Residents R14 s and R1 s me were reviewed for clinical indications gradual dose reductions (GDR) made when the clinical indication the benefit outweighs the risk to and the rationale is documented patient chart.  Element 2 All residents who take psychotr medications were assessed for for use, appropriateness of grade reduction and documented rationally be reviewed for appropriate indications for use. The consult pharmacist will audit all residen medication regimens monthly, will monitor all psychotropic me for gradual dose reductions and documented benefit vs risk rational least quarterly. SW, consulting pharmacist and RNs were eductions.  Element 4 The consulting pharmacist will a resident s medication regime resident s medication regime resident medication regimen at least quarterly.	attions, were ons reveal of decrease d in the  opic indications dual dose onale.  odated as edications ting t s SW/RN dications d onale at cated aal dose  audit each monthly. nt		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIE	R ION & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 329	encourage the rest to participate in a During the survey 4:00 p.m. to 8:00 to 4:30 p.m., on 1 p.m., on 10/2/14, on 10/3/14, from was observed to wheel himself are with other resider not observed to do On 10/1/14, at 12 (RN)-A stated R1 is depressed. She other symptoms of The Consultant P completed on 12/Medicare/Medica two gradual dose first year for all ps medication to det the order." "Consany reduction work psychiatric distression is did not address we contraindicated.  On 10/1/14, at 1:3 the consultant ph antidepressant mattention of the plantice of the property of the property of the property of the survey of the property of the survey of the property of th	the care plan directed the staff to sident to stay up after meals and ctivities in the facility.  The conducted on 9/29/14, from p.m., on 9/30/14, from 8:00 a.m. 0/1/14, from 7:00 a.m. to 3:30 from 8:00 a.m. to 4:30 p.m., and 8:00 a.m. to 12:00 p.m., R14 participate in activities of choice, and the facility, and interacted ats, staff and visitors. R14 was isplay symptoms of depression.  120 p.m. registered nurse 4 will occasional sleep when he a stated R14 does not show any	F3	329	The DON/designee will monitor psychotropic medications for GDR documentation of rationale explain benefit vs risk weekly x 4 weeks, the monthly x 2 months and thereafter quarterly. Variances will be reported the Administrator for immediate fol and reviewed at QAPI at least quarterly.	ing the nen ed to low up	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING		10/	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 329	does not show any depression.	R14 occasionally naps but other symptoms of	F 329	9			
	indicated diagnose dysthmic disorder of thoracic spondylos of the joints between vertebrae) and inso	nission Record dated 10/2/14, is that included chronic pain, (a chronic type of depression), is (degenerative osteoarthritis en the center of the spinal pmnia. The current physician's 2/14, directed nortriptyline (an at bedtime.					
	was cognitively into	S dated 7/10/14, indicated R1 act. The MDS also indicated ite or overeating 2-6 days, felt 2-6 days, and received dication daily					
	1/10/14, indicated aware of reasons f willingly to psych vinew symptoms. To potential for unwar	Medication Use CAA dated R1 was alert and oriented, and or medication use. He went sits and was able to self report the CAA also indicated a lated side effects from the use expressant medications.					
	received nortriptyling goal for R1 to recemedication to allevinsomnia. The car	ed 7/16/14, indicated R1 ne for sleep and identified a ive the lowest dose of iate signs and symptoms of e plan directed staff to monitor otoms of depression, anxiety					
	Regimen Review F	armacist's Medication Report dated 7/25/12, identified arted October 2011 and was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING		10	/03/2014	
	PROVIDER OR SUPPLIE	R ION & LIVING CENTER		STREET ADDRESS, CITY, STATE  115 10TH AVENUE NORTHEAS  DEER RIVER, MN 56636	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	along with insommed along with insommed area and participating in a lounge area. R1 and participating and R1 was smilling and long area. R1 and been done for RN-A stated the five area and this had a long and the smooth of the should have been completed and the should have been DON confirmed spharmacist to have monitoring for the long and long area well. R1 stated he asleep throughout does wake during sleep without diffinance and had no difficulting and long	ronic pain and neuropathies, nia and depression.  Ord indicated the most recent assessment was dated  It 2:14 p.m. R1 was observed been bag toss activity in the was observed to be engaged in the activity. His affect was fulling.  It 1:10 p.m. RN-A stated the continuous process had just and they were planning to start a confirmed no sleep monitoring rR1 since December 2013. acility had lost some staff last been missed.  It 8:38 a.m. interim director of onfirmed sleep monitoring had ed since December 2013, and not as directed by the care plan, he would have expected the receive identified the lack of sleep medication.  It 9:18:a.m. R1 stated he slept is able to fall asleep and stay to the night. R1 also stated if he put the night, he is able to return to coulty. R1 further stated he was edication regimen at this time alties.	F3	329			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/03/2014	
	PROVIDER OR SUPPLIEF	ON & LIVING CENTER		115 10	T ADDRESS, CITY, STATE, ZIP CODE TH AVENUE NORTHEAST RIVER, MN 56636	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 356 SS=C	INFORMATION  The facility must particle daily basis: o Facility name. o The current date or The total number by the following care unlicensed nursing resident care personal nurses - Registered name or Certified nurses - Certified nurse	ar and the actual hours worked ategories of licensed and g staff directly responsible for shift: urses. ctical nurses or licensed (as defined under State law). Se aides. St. cost the nurse staffing data in a daily basis at the beginning a must be posted as follows: ble format. clace readily accessible to ors. cupon oral or written request, and data available to the public st not to exceed the community chaintain the posted daily nurse minimum of 18 months, or as aw, whichever is greater.	F3	El	ement # 1 e Staff posting was immediately		11/15/14
	for review at a cosstandard.  The facility must no staffing data for a required by State.  This REQUIREMED by: Based on observative review, the facility worked for each costandard.	naintain the posted daily nurse minimum of 18 months, or as law, whichever is greater.  ENT is not met as evidenced ation, interview and document		Th			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245428	B. WING _			10/0	03/2014
	ROVIDER OR SUPPLIER  EAD REHABILITATIO	N & LIVING CENTER		115	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428 SS=D	affect all 26 resident any visitors who mainformation  Findings include:  On 9/30/14, at apprinitial tour of the fact posting was located nurse's desk. The mactual hours worked non-licensed staff.  Review of the nurse 10/1/14, and 10/2/1 worked by licensed  On 10/2/14, at 9:05 (DON) verified the minclude actual hours non-licensed staff. current nurse staff play, p.m., and night who worked short of the Nurse Staffing 12/30/12, did not achours on short shift worked.  483.60(c) DRUG RIRREGULAR, ACT  The drug regimen of reviewed at least or pharmacist.	d. This had the potential to ats residing in the facility, and ay have wanted to review the coximately 1:00 p.m. during the cility, the daily nurse staff in a clear frame at the nurse staff posting lacked the doby licensed and estaff postings for 9/29/14, 4, all lacked the actual hours and non-licensed staff.  a.m. the director of nursing nurse staff posting did not is worked by licensed and The DON also stated the costing form only indicated it shifts, and did not list staff or split shifts.  Requirement policy dated didress the posting of actual is or split shifts that staff in the control of the cost in the posting of actual is or split shifts that staff in the cost in the posting of actual is or split shifts that staff in the cost in th	F 3		Element # 2 Nurse staffing information is posted in an area and at a height readily so residents and families. Staffing postept in a book at the nurse is statical months.  Element # 3 A policy has been implemented and educated to licensed staff regarding requirements of nursing staff posting.  Element # 4 Postings will be audited by the Dire Nursing/Designee Daily x 7 days, the weekly x 3 weeks and at least mon months. Random audits of staffing and posting will be at least quarterly ongoing. Exceptions will be reported the Administrator for immediate foll and reviewed at QA at least quarter.	een by its are on for  d g ngs.  ctor of nen thly x 2 book y ed to ow up	11/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10/0	10/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 428	the attending phys nursing, and these This REQUIREME by:	age 55 ician, and the director of reports must be acted upon.  NT is not met as evidenced ation, interview and document	F 42	Element 1			
	review, the consult and report on the e 2 of 3 residents (R In addition, the cor identify the need for continued need for and failed to identife efficacy of an antic for 2 of 5 residents unnecessary medi.  Findings include:  R6's quarterly Mini 9/3/14, also indicate required extensive activities of daily live.	ant pharmacist failed to identify efficacy of pain medications for 6, R11) who had chronic pain. It is a constant pharmacist failed to or a dosage reduction and/or the use of an antidepressant, for the lack of monitoring for depressant used for insomnia is (R14, R1) reviewed for		The consulting Pharmacist has rest the medication irregularities related PRN pain medications for resider R11, who had chronic pain. Charmacist been made as recommended consulting pharmacist reviewed FR1 is routing medication irregular made recommendations as approximate the consulting pharmacist has resident charts for PRN and resident appropriate recommendations.  Element 3  The policy and contract regarding consulting pharmacy services and	ed to hts R6, hges ed. The R14 and rities and opriate. eviewed outine le		
	including cerebral mellitus and congerals of indicated R6 s which prevented hactivities. During treported her pain tworst) pain scale.  R6's care plan date	palsy, anxiety, diabetes estive heart failure. The MDS suffered from frequent pain er from participating in daily he assessment period, R6 had o be at a 6 on a 0-10 ( 10 is ed 6/4/14, identified an rt related to numbness/tingling		medication review was reviewed consulting pharmacist. The cons pharmacist has access to the EN efficiency of pharmacy review.  Element 4 The DON/Designee will audit the consulting pharmacist report mor ongoing. Variances will be report Administrator for immediate follow reviewed at QAPI at least quarter	with the ulting IR for hthly led to the w up and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 56	F 4	128	3		
	and muscle spastic palsy. The plan dir needs and respond plan did not direct s potential leg pain al	dary to carpal tunnel syndrome ity secondary to cerebral ected staff to anticipate her I in a timely manner. The care staff on how to minimize and it did not include tal interventions to minimize					
	included Baclofen times a day, Gabal treat nerve pain) 30 a day, Tylenol extra every four hours as Fentanyl (narcotic p	er Report dated 9/5/14, (muscle relaxer) 10 mg three pentin (medication used to 00 milligrams (mg) three times a strength 500 mg one tablet is needed (PRN) for pain, and pain patch) 25 micrograms hanged every three days.					
	in a wheelchair in th	a.m. R6 was observed seated ne dining room. R6 began to ng down her face calling out to Oh, oh oh."					
	in a wheelchair in the cry, "Ey, ey, ey, oh	a.m. R6 was observed seated ne dining room. R6 began to that leg." R6 turned her head mbers and began to cry "oh he shook her head.					
	cried out in pain ever complain while sitting reported R6 receives management but slatime for the next material for the next pain metals.						
	On 10/2/14, at 9:45	a.m. R6 stated she					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		115	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 428	ask for Tylenol. Sheare of the pain for the pain in her left often had to watch dose of pain medicat an 8 or 9 on a 0 she has to watch the receiving her pain.  Review of the elect administration receiving information in receiving information receiving information in receiving information in receiving information receiving info	n her left leg every day and will be explained the Tylenol takes or about an hour. R6 explained leg woke her at night and she of the clock to wait for her next cation. R6 described the pain -10 pain scale daily. R6 stated the clock to make sure she is medications.  Stronic medication for (EMAR) revealed the on about excessive use of as a second to the clock to make sure she is medications.  The following	F 4	228			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245428	B. WING _		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 428	with the interim dire consultant register DON stated she with daily. The two RNs and were unable to staff had complete assessment of R6' determine if the Fe in 7/2014, was an econtrolling the pain. On 10/2/14, at 11:2 confirmed R6 expebeen comprehensi to determine the expension of the treatment of was utilizing over 7. Review of the mon medication regime had been complete identified by the phonon of the treatment of the treatme	20 a.m. R6's pain was reviewed ector of nursing (DON) and the ed nurse (RN). The interim as aware R6 expressed pain is reviewed R6's clinical record of find indication in which the da comprehensive is pain and were unable to entanyl which had been added effective medication for it.  20 a.m. the consultant RN erienced pain daily and had not evely reassessed by the nurses extent of the pain. She stated was utilizing PRN medications if pain but was not aware she if OPRN medications per month. The consultant pharmacist in reviews indicated the reviews ed without any type of concerns armacist.  20 p.m. the consultant she started visiting the facility the stated at the time of the it have access to the electronic EMARs. She confirmed she is R6's PRN medication usage as a ccess at the time of the review. Yould have noted that a ng over 80 PRN doses of pain month, she would have pointed	F 42	28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	,	
(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 SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	requested and none R11's Physician Or 9/3/14-10/3/14, indiincluded osteoporo become fragile and leg osteoarthritis (d the cartilage), chror granulomatosis (cavessels). R11's significant chindicated R11 had sand required extens locomotion on and personal hygiene a staff for bed mobilit and corridor and to indicated R11 receipain medication and for pain. The MDS her pain as modera interfere with daily a sleep at night. The received physical the therapy (OT) service of motion (ROM) received physical that the same plan datalteration in comfor history of compressindicated R11 would on a verbal scale of pain medication. Tadminister medication in comfor history of compressindicated R11 would on a verbal scale of pain medication. Tadminister medication. Tadminister medication in comfor for effective possible side effect.	der Report dated cated R11 had diagnoses that sis (a disease in which bones more likely to fracture), lower egenerative arthritis affecting nic pain, and Wegener's uses inflammation of the blood ange MDS dated 8/11/14, severe cognitive impairment sive assistance of one staff for off the unit, dressing and nd limited assistance of one y, transfer, ambulating in room illet use. The MDS also ved scheduled and as needed d non-medication interventions also indicated R11 reported ate and frequent but it did not activities or make it difficult to MDS further indicated R11 nerapy (PT) and occupational les and received active range estorative nursing services.  ded 7/17/14, identified R11 had at related to pain secondary to sion fractures of her back and d verbally state pain was 2-3 f 0-10 after administration of he care plan directed staff to ions as ordered for pain and to eness of pain medications and		128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		115	REET ADDRESS, CITY, STATE, ZIP CODE 1 10TH AVENUE NORTHEAST ER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	physician's impress vertebral compress The physician's pla medications until R (identified upon phyevaluated.  R11 was hospitalize 8/4/14, for pneumo  The facility complete R11 on 8/5/14 - 8/9 summary of the data 8/13/14, identified R during the assessm  The Physician Orde 9/3/14-10/3/14, includesive patch (a I milligrams (mg)/pattopically to mid-back hours for chronic pareliever for modera three times a day (suppressed to mid-back twice a day PRN for 500 mg 1 tab every	earing and intake issues. The sion included pain issues with sion fractures and arthritis. In was to not change 11's shortness of breath visician examination) was ed from 7/31/14 through nia.  Ited Pain Data Collection for 1/14. The RN assessment ta collection completed on R11 had complained of pain nent period.  Iter Report dated (uded orders for Lidoderm ocal anesthetic) 5% (700 tch) apply 1 new patch ek daily on 12 hours and off 12 ain, Norco (narcotic pain te to severe pain) 5-325 mg scheduled dose), Norco (aminophen) 5-325 mg 1 tab or pain, and acetaminophen 1/26 hours PRN for pain.	F 4	-28	DEFICIENCY)		
	8/8/14 -10/3/14 rev -Lidoderm adhe administered early days. -Norco 5-325 m dose) was given ea 8/25, 9/12, 9/22, 9/2	dministration History dated ealed: sive patch 5% was at R11's request 30 of 57 g three times a day (scheduled arly for the morning dose on 25, 9/26, 9/29, 9/30, 10/1, for the afternoon dose on 9/9					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245428	B. WING _		10	/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 428	(11 doses).  R11's PRN Medica 8/8/14-10/3/14 reventors 5-325 m doses were given of pain in knees or acetaminopher as needed was given three timpain in knees or leventors and given three timpain in knees or leventors and given three timpain in knees or leventors and began to observed to be swe given pain pills for lasted a little while She stated that on packs, as well, and stated the pain keet that the previous not finally got a pain pill identified her pain on 10/2/14, at 10:4 seated in her room walker in front of holimited her activities her from joining in. R11 stated her knee a 7 out of 10 on a her knee hurt all the	ations Administration History ealed: ag 1 tab twice a day PRN, 32 on 29 of 57 days for complaints legs. a 500 mg 1 tab every 6 hours en once on 8/8, 8/30, and 9/3 hes on 10/2 for complaints of	F 42	28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636	1 10/	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	walking made her k On 10/02/2014, at received scheduled day and could also her knee pain. She pain medication, it is night shift but was a day. LPN-B stated Review of the mont medication regiment had been complete regarding pain man pharmacist. On 10/2/14, at 3:45 pharmacist stated so one month ago. She consult, she did not medical records or had not reviewed R she did not have accepted as the service of the	2:39 p.m. LPN-B stated R11 I pain medication three times a have PRN pain medication for stated if R11 asked for extra was usually needed on the occasionally given during the PRN Norco was usually given.  The consultant pharmacist is reviews indicated the reviews dividually dividually concerns agement identified by the p.m. the consultant she started visiting the facility is stated at the time of the shave access to the electronic EMARs. She confirmed she access at the time of the review.	F	128			
	directed Paxil (an a mg daily for the trea medication was sta record lacked docu dose reduction sind addition, the record reduction would be	der Report dated 9/3/14, ntidepressant medication) 10 atment of depression. The rted on 7/3/2013. The clinical mentation of an attempted se start date of 7/13. In lacked documentation why a contraindicated for R14.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	being alert and orie concerns. The assereceived antidepress received antidepress. The Psychotropic Massessment dated participated in activity depression.  The care plan datereceiving antidepression antidepression and seeplessness. The encourage the reside to participate in activity depression and seeplessness. The encourage the reside to participate in activity depression.  The Consultant Phacompleted on 12/10 Medicare/Medicaid two gradual dose refirst year for all psymedication to deter the order." "Considering any reduction would psychiatric distression benefits for this dos "He is on the lowes his depression is good in address which contraindicated."  On 10/1/14, at 1:30	7/1014, identified R14 as ented with no mood or behavior ressment indicated R14 as ant medications daily.  Medication Use Care Area 7/10/14, indicated R14 rities and did not show signs of d 7/15/14, identified R14 as assant medication for the depression and e care plan directed the staff to dent to stay up after meals and	F 4	28			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED				
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE  15 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	attention of the phy the medication has time. RN-B stated F does not show any depression.  On 10/2/14, at 4:00 pharmacist stated sone month ago. Sh consult, she did not medical records or noticed R14 was reshe should make a until she could reviet to know the resident confirmed residents were to receive two during the first year.  R1's Resident Admindicated diagnoses dysthmic disorder (thoracic spondylosi of the joints between vertebrae) and inscorders printed 10/2 antidepressant) 50.  R1's quarterly MDS was cognitively inta R1 had poor appetit bad about himself 2	dication reduction to the sician in 12/13, but confirmed not been addressed since that R14 occasionally naps but other symptoms of  p.m. the consultant she started visiting the facility he stated at the time of the have access to the electronic EMARs. She stated she had ceiving Paxil but did not feel my type of recommendations at the clinical record and get at a bit more. The pharmacist is receiving antidepressants attempted dose reductions attempted dose reductions in the center of the spinal simple. The current physician's fully directed nortriptyline (an at bedtime.  It dated 7/10/14, indicated R1 of the MDS also indicated the or overeating 2-6 days, felt 2-6 days, and received	F 4	128			
	received nortriptylin	ed 7/16/14, indicated R1 the for sleep and identified a tive the lowest dose of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	insomnia. The care for signs and symp and insomnia.  The Consultant Pha Regimen Review R nortriptyline was staprescribed for chroalong with insomnia.  Review of the mont medication reviews been completed with nortriptyline use idea.  R1's medical record sleep monitoring as December 2013.  On 10/01/2014, at facility's side effect been reorganized a on 10/1/14. RN-A chad been done for RN-A stated the fact year and this had been done for RN-A stated the fact year and this had been confirmed sleep monitorimed sleep monitorimed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she wou pharmacist to have monitoring for the reconfirmed she would be reconfirmed she w	ate signs and symptoms of e plan directed staff to monitor toms of depression, anxiety  armacist's Medication eport dated 7/25/12, identified arted October 2011 and was nic pain and neuropathies, a and depression.  The consultant pharmacist indicated the reviews had thout any concerns regarding entified by the pharmacist.  If indicated the most recent esessment was dated  1:10 p.m. RN-A stated the monitoring process had just and they were planning to start confirmed no sleep monitoring R1 since December 2013. Eility had lost some staff last een missed.  8:38 a.m. interim DON conitoring had not been ecember 2013, and should cited by the care plan. DON lid have expected the identified the lack of sleep	F 4	128			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	` '	E SURVEY IPLETED
		245428	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHOI  CROSS-REFERENCED TO THE APPR  DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	the residents and the physician may have R1's nortriptyline us pain rather than for suspended sleep may be seen the residents and the physician may be successful.	had a chance to get to know heir history. She stated the changed the indication for se to address his neurogenic sleep and then may have nonitoring.	F 4	28		
F 441 SS=F	483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Prosafe, sanitary and control to help prevent the of disease and infection Control The facility must es Program under whice (1) Investigates, coin the facility; (2) Decides what proposition in the facility; (2) Decides what proposition is a reconstruction of the preventing Spreading	tablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.  Il Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections.  The add of Infection in the control program resident needs isolation to of infection, the facility must	F 4	41		11/12/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIE	ION & LIVING CENTER		115	REET ADDRESS, CITY, STATE, ZIP CODE 5 10TH AVENUE NORTHEAST EER RIVER, MN 56636		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	hand washing is in professional pract (c) Linens Personnel must h transport linens so infection.	direct resident contact for which indicated by accepted ice.  andle, store, process and ico as to prevent the spread of	F 4	41			
	by: Based on observer review, the facility control practices of R10, R32, R31, R glucose monitorin sugar levels. In accontrol (IC) prograp program and invertracking trends and interventions to program the lack of surveities of the 26 residual Findings include:  On 9/29/14, at 5:2 (LPN)-C applied of R4's finger to che blood glucose monitorior reviews and the surveities of the surveities o	ation, interview, and document failed to use proper infection for 7 of 7 residents (R3, R2, 6, R4) who used a blood g machine to check their blood ddition, the facility's infection am lacked a surveillance stigation of infections for ad analysis of data to determine revent the spread of infections. Illance had the potential to affect ents who resided in the facility.			Element 1 The facility reviewed the infection of surveillance program and found it he completed after May 2014. Surveil including investigation, trending and analysis of data to determine intervation prevent the spread of infections of completed for June, July, and Augu 2014. The product used for cleansing glucometer was immediately change an EPA approved germicidal cleans.  Element 2 The facility completed surveillance September, 2014 and nursing is identifying infections and antibiotic they occur. An EPA approved germicleanser is used on all glucometers facility.	and not lance, dentions was last, and to ser.	
	all the residents we checks. LPN-C was machine with a sa information indica	the one facility BGM machine for the required blood sugar as observed to clean the BGM ani wipe towelette. The package ted the towelette contained the 70% alcohol antiseptic.			Element 3 The policy regarding IC surveillance reviewed and the policy regarding cleansing of glucometers was upda appropriate. Licensed nursing staff educated regarding IC surveillance	ited as f was	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245428	B. WING			10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1′	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST EER RIVER, MN 56636	,	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	blood sugar checks R2 had a physician blood sugar checks R10 had a physician blood sugar checks R32 had a physician blood sugar checks R31 had a physician blood sugar checks R6 had a physician blood sugar checks R4 had a physician blood sugar checks R5 had a physician blood sugar checks R6 had a p	's order dated 7/22/13, for a twice daily four days a week. 's order dated 9/19/14, for a daily.  n's order dated 6/10/13, for a three times a day.  n's order dated 9/25/14, for a four times a day.  n's order dated 8/21/14, for a four times a day.  's order dated 12/6/13, for a daily.  's order dated 12/26/13, for a four times a day.  p.m. LPN-C stated they were use the sani wipe clothes as a the BGM machine. LPN-C structed to only use the sani da sign indicating this was	F	141	cleansing of glucometers. An infection of nurse has been identified a trained regarding surveillance and glucometer cleansing.  Element 4 The Administrator/Designee will as surveillance monthly x 3 months a quarterly ongoing. Variances will be reviewed at QAPI at least quarterly.	nd  udit IC  nd then e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245428	B. WING _		10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	N & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	their disinfecting promachine back to the blood borne pathog the sani wipe towel and inactive ingredictions. At 10:45 a.m. the conchecked with the lait had been about a product was changed.  SURVEILLANCE On 10/2/14, at 8:51 May 2014, was the resident infections attended the RN who tracking had resign surveillance for residential completed.  The Surveillance of Infections policy revinfection control office.	stated they were changing oduct that day for the BGM e sani wipe clothes that do kill ens. The consulting RN stated ettes only contained alcohol ents.  Onsulting RN stated she boratory personnel and stated month since the disinfecting	F 4	11		
F 465 SS=E	the direction of the Control Committee.  A policy was reques of the accu check in provided.  483.70(h) SAFE/FUNCTIONAE ENVIRON  The facility must provided.	Infection Prevention and	F 40	65		11/12/14

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245428	B. WING _		10/0	03/2014	
	PROVIDER OR SUPPLIE	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	•		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	by: Based on observereview, the facility rooms and commerce and facility rooms and commerce and facility rooms and commerce and facility for the south and facility and facility from the chair rail areas on the sufference and the chair rail areas on the wall of the chair rail areas on the wall of the chair rail areas on the wall.  The West wall of the chair rail areas on the wall.  The West wall of the chair rail areas on the wall.  The West wall of the chair rail areas on the wall.  The Deack North of the chair rail areas on the wall.  The MD stated the of plastic. The MD could be removed.	ent the public.  ENT is not met as evidenced ation, interview, and document failed to maintain resident on areas clean and in good esident rooms (#121, 126, 132, 4 and 105) and throughout the cility corridors.  45 a.m. a tour of the facility was a maintenance director (MD). The dining room had black scuff tely 4 feet by a 1 foot area. The dining room was 22 feet long ailing. Approximately 4 inches air railing were numerous black wall. The dining room was 5 feet long. Approximately 4 inches downing were numerous black scuff	F 4	Element 1 Resident rooms (121, 126, 1 103, 104, 105), bathrooms, a areas as identified during the been maintained, cleansed a  Element 2 An audit of resident rooms, b and common areas was perf identification of other areas in maintenance, cleansing or pa  Element 3 A mechanism is in place for a notification of resident rooms and common areas in need of maintenance, cleansing or pa staff has been educated on in reporting, and obligation to p and sanitary conditions. Ther for maintenance to observe r rooms, bathrooms, and commoneed of maintenance, cleans  Element 4 The Administrator/Designee maintenance observation sch repair work weekly x 4 weeks monthly x 2 months and qual ongoing. Variances will be re QAPI at least quarterly.	end common e survey have and painted. Pathrooms, ormed for n need of ainting. maintenance s, bathrooms, of ainting. All dentify, rovide clean re is schedule resident mon areas in sing, paint. will audit needule and s, then rterly		

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

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  IG	(X3) DATE S		
		245428	B. WING _		10/03	/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	, 1999	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 465	Continued From pa	age 71	F 46	55		
	was 8 feet by 10 in scuff marks.  -The West wall out feet by 15 inches warks.  -The West corridor feet by 12 inches warks.  -The East wall outs by 12 inches with reserved inches by 3 feet, are black scuff marks.  -The West wall of the inches. The South the East wall was 7 numerous black scuff marks.  -In room 121 there wooden door to the lin room 126 there missing from the well room 101 the waddition, there was over the chipped was gouges in the wooden. The South was numerous black scuff marks.	were several gouges in the eroom. was sheetrock and paint alls. were several gouges in the eroom. alls had black scuff marks. In duct tape on the door face rood. There were several den door to the room. was paint missing above the all was 80 inches by 3 feet with suff marks were several gouges in the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245428	B. WING			10/0	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	with numerous black- In room 105 the back- 45 inches by 7 inches	th wall was 4 feet by 1 foot ck scuff marks. athroom register had an area les scraped down to the bare all was 41 inches by 13 inches	F 4	65			
	numerous black sc the plastic walls. -The North hallway	ullway 100 feet long had uff marks on the lower level of 74 feet long had numerous on the lower level of the plastic					
	wheelchairs and me The MD stated the	black scuff marks were from echanical lifts hitting the walls. housekeeping staff did the ne maintenance staff would do painting.					
	(MS)-A stated an a	2 p.m. maintenance staff nnual building inspection was ember 2014, and had not been					
	manager (NSM) sta monitoring the hous NSM stated there h housekeepers, and	a.m. the nutrition services ated she took over the role of sekeepers in April 2014. The had been turnover with the they were short in the artment and there were two					
	cleaning during an spring. The NSM st	SM stated they do extra eight week period in the tated there was no cleaning was done.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245428	B. WING		10/03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	
(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 APPROPI DEFICIENCY)	BE COMPLÉTION
F 465	indicated the facility clean, sanitary, and extra cleaning which	deeping policy dated 1/91, would be maintained in a discrete orderly condition. During the h covered an eight week in hallways, resident rooms all be washed.	F 465 F 497		11/12/14
SS=E	REVIEW-12 HR/YF  The facility must co of every nurse aide months, and must peducation based or reviews. The in-se sufficient to ensure nurse aides, but me per year; address a determined in nurse and may address th as determined by th aides providing ser	emplete a performance review at least once every 12 provide regular in-service in the outcome of these revice training must be the continuing competence of just be no less than 12 hours areas of weakness as a aides' performance reviews the special needs of residents the facility staff; and for nurse vices to individuals with ints, also address the care of	1 497		11/12/14
	by: Based on interview facility failed to prove 6 nursing assistant reviewed that have greater than 12 modern Findings include:  NA-H was hired on Employee Performance.	NT is not met as evidenced and document review, the vide annual evaluations for 4 of s, (NA-H NA-E, NA-D, NA-G) worked in the facility for nths.  8/2/07. NA-H's most current ance Appraisal was dated been reviewed with NA-H.		Element 1 Nurse assistant evaluations for NA NA-E, NA-D, NA-G, NA-H, and NA have been completed.  Element 2 An audit of recent of nurse assistar evaluations was performed and evaluations have been completed of nurse assistants for 2014.	-B

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245428	B. WING		10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(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) COMPLETION DATE
F 497	NA-E was hired on Employee Performs 2012. The Perform reviewed with NA-E current annual performs 2012. The Performs 2014. The Performs 2014. The Performs 2015 annual performs 2015 annual performs 2016 annual performs 2016 annual performs 2017. The Employee Performs 2018 annual p	ile lacked a current annual v.  4/15/04. NA-E's last ance Appraisal was dated nance Appraisal had not been E. Her personnel file lacked a ormance review.  11/10/03. NA-D's last ance Appraisal was dated nance Appraisal had not been D. Her personnel file lacked a ormance review.  5/14/90. NA-G's last ance Appraisal was dated nance Appraisal was dated nance Appraisal had not been D. Her personnel file lacked a ormance review.  0 a.m. the consultant and not been completing the employee evaluations. She stated she luations had not been not the facility had set a goal to ed by October 1, 2014. She onnel files lacked annual actions.  formance Evaluations policy ated annual evaluations were	F 497	Element 3 Policy has been reviewed and edu has been provided to the nurse assistants supervisors (RNs) reg the requirement for annual evaluat nurse assistants.  Element 4 The DON/Designee will audit compof nurse assistant evaluations ann November. Variances will be review QAPI at least quarterly.	arding ions of oletion ually by	

F5428023

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

CLIVILLI	S FOR MEDICARE	& MEDICAID SERVICES			71110000	TUBLITO	. 0930-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .		E CONSTRUCTION 01 - NURSING HOME	(X3) DATE SURVEY COMPLETED		
		245428	B. WING			09/	30/2014	
	ROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE	
K 000	INITIAL COMMEN	тѕ	K	000				
	FIRE SAFETY							
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.						
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.						
	Minnesota Departr time of this survey Living Center 01 M substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety. At the Homestead Rehabilitation and ain Building was found not in ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the cional Fire Protection  Standard 101, Life Safety ter 19 Existing Health Care.						
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY			EDOC			
	Health Care Fire In State Fire Marshal 445 Minnesota Stro St. Paul, MN 5510	Division eet, Suite 145			<b>EPOC</b>			
	Or by e-mail to:							
BORATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

Electronically Signed

10/30/2014

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

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	(V2) MIII	TIDI	LE CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		01 - NURSING HOME	COMPLETED	
		245428	B. WING			09/3	30/2014
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the defic  2. The actual, or pr  3. The name and/oresponsible for corprevent a reoccurre Homestead Rehab 1-story building wit attached to a hosp constructed in 2 mbuilding was constructed in 2 mbuilding was constructed and was in a determined to be of 1990 an addition to constructed and was in li(111) construction from the nursing hebarriers and was in building is divided in accordance with Installation of Sprir with quick respons K56. The facility is moke detection the in spaces open to rooms that is monit department notification.	RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done		000			

Event ID: 5J6W21

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG <b>01 - NURSING HOME</b>	(X3) DATI	E SURVEY PLETED
		245428	B. WING			30/2014
	PROVIDER OR SUPPLIER EAD REHABILITATION	ON & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 052 SS=F	(1999 edition). Oth automatic fire determined and system in accordant Fire Code (2007 edition of Consultation	er hazardous areas have ction that are on the fire alarm nee with the Minnesota State dition)  apacity of 32 beds and had a setime of the survey.  al building and its additions ion type allowed for existing y was surveyed as a single  42 CFR, Subpart 483.70(a) is enced by:  FETY CODE STANDARD  a required for life safety is and maintained in accordance onal Electrical Code and NFPA is an approved maintenance in complying with applicable	K O			11/12/14
	Based on observa fire alarm system is conformance with	NFPA 70(99) and NFPA 72(99) s deficient practice could affect		K052 Fire alarm system test was of July 2 2014. All fire alarm sy will be inserted into a docum upon receipt. Fire alarm systems	stem tests ent binder	

Event ID: 5J6W21

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - NURSING HOME		TE SURVEY MPLETED	
		245428	B. WING			09/30/2014		
	PROVIDER OR SUPPLIER	ON & LIVING CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST EER RIVER, MN 56636			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 052 K 062 SS=F	At the conclusion of approximately 9:00 available documen annually required in maintenance of the accordance with NI 7-13.  This deficient practifacility Maintained I this inspection.  NFPA 101 LIFE SA  Required automatic continuously maintained are in the condition and are in the condition of the conclusion of the c	of the inspection tour at AM, on 9-30-14, review of tation indicated that the last respection, testing, and a fire alarm system, in FPA 72, was conducted on the conducted on th		062	with all devices will be inspected certified annually by an outside f testing company who will remain agreement to meet NFPA-72 requirements.	ire alarm	11/12/14	
	Based on record reinterview, the facilit maintain the sprink practice could affect residents, staff and Findings include:  At the conclusion of approximately 9:00 review of available with the Director of	s not met as evidenced by: eview,observation and y has failed to properly ler system. This deficient et all occupants including visitors.  If the tour on 9-30-14 at AM, it was discovered, during documentation, and interview Facility Maintenance, that the the licensed vendor conduct		5 d	Sprinkler system testing had be scheduled and was completed o 10-2-2014. Fire suppression sys be tested quarterly and certified by an outside sprinkler testing cowho will remain under agreemen NFPA-25 requirements.	n tem will annually ompany		

Facility ID: 00296

PRINTED: 11/06/2014 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU				E CONSTRUCTION 01 - NURSING HOME	(X3) DATE SURVEY COMPLETED	
		245428	B. WING			09/	30/2014
	PROVIDER OR SUPPLIER EAD REHABILITATION	ON & LIVING CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 15 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 062 K 069 SS=D	maintance done or sprinkler system si NFPA 25.  This deficient pract Director of Mainter NFPA 101 LIFE SA Cooking facilities a with 9.2.3. 19.3.2  This STANDARD Based on review of kitchen hood exting properly being mai MSFC (07) section deficient practice occupants in the extinguishment system of months ago. This months.	il inspection, testing and the complete automatic fire nce 7-16-13, as required by tice was confirmed by the nance (MC) at the time of exit.  AFETY CODE STANDARD  The protected in accordance		062	Cooking Equipment Ansul system been scheduled and was tested on 2014. The kitchen ansul fire suppresystem will be tested and certified bi-annually by an outside sprinkler company who will remain under agreement to meet NFPA-25 requirements.	10-2- ession	11/12/14
					pi		

Event ID: 5J6W21



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted October 22, 2014

Mr. Michael Hedrix, Administrator Homestead Rehabilitation & Living Center 115 10th Avenue Northeast Deer River, Minnesota 56636

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5428024

Dear Mr. Hedrix:

The above facility was surveyed on September 29, 2014 through October 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules . At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Homestead Rehabilitation & Living Center October 22, 2014 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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

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

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

Sincerely,

Mark Weath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697

5428s15lic

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ 00296 B. WING 10/03/2014

		00296		5		10/03	5/2014
	HOMESTEAD REHABILITATION & LIVING CEN. 115 10TH		AVENUE NO	VENUE NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	ES Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Initial Comments  ****ATTENTION*****			2 000			
	In accordance with I 144A.10, this correct pursuant to a survey	ction order has been y. If, upon reinspec	section n issued ction, it is				
	found that the defici herein are not corre not corrected shall be with a schedule of fi the Minnesota Depar	cted, a fine for each be assessed in acc ines promulgated b	h violation ordance				
	Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with an result in the assessing that was violated ducorrected.	compliance with all rule provided at the le number indicated as several items, fathe items will be concard to form the concard of multi-parment of a fine even	e tag d below. ilure to nsidered te upon t rule will if the item				
	You may request a I that may result from orders provided that the Department with notice of assessmen	n non-compliance wat a written request in hin 15 days of recei	vith these s made to pt of a				
	INITIAL COMMENT On 9/29/14, 9/30/14 10/3/14, surveyors of visited the above pro- correction orders are are completed, pleat copy of these orders Minnesota Department	I, 10/1/14, 10/2/14, of this Department's ovider and the follo e issued. When cose sign and date, read and return the original to the sign and the original to the original that the original th	s staff, wing orrections make a ginal to the				

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

TITLE

**Electronically Signed** 

(X6) DATE 10/31/14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED		
		00296		B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN	115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Compliance Monito	ring, Licensing and m,705 5th street Sui	te A,	2 000			
2 302	DISORDER TRAIN MN St. Statute 144.  (a) If a nursing facil Alzheimer's disease or related of segregated or generate staff and their supervisor care.  (b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	EASE OR RELATED ING: .6503 ity serves persons we disorders, whether interal unit, the facility's are must be trained in distributed training include: of Alzheimer's disease activities of daily living with challenging beh	ith  a direct dementia e and ng; naviors; rs in of the loyees e basic	2 302			11/12/14
	by:	ent is not met as evi			The facility provided information to	)	

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 2 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED		
		00296		B. WING		10/03/2014	
	PROVIDER OR SUPPLIER	N & LIVING CEN	115 10TH	DDRESS, CITY, STATE, ZIP CODE  H AVENUE NORTHEAST  IVER, MN 56636			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 302	description of the A provided at the facilithe potential to affe consumers who was Findings include:  On 10/2/14, at 1:37 nurse (RN) stated sand others had bee dementia training a would not be documented.	ge 2 eived information on Izheimer's training prolity for employees. The ct all 26 residents and the training process of the training of training of the training of training	registered council er, there at the	2 302	consumers regarding the Alzheim training program as Required by s federal regulators via local news p	state and	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents  Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).  This MN Requirement is not met as evidenced by:		2 560	Floment 1		11/12/14	
	Based on observation review, the facility for address medication interventions to me residents (R31) who reviewed; failed to opain interventions for a service of the servi	on, interview and doc ailed to develop a can as and appropriate et the needs for 1 of ose medication regind develop a care plan ror 3 of 3 residents (Ressed pain; and failed	5 nen was elated to 6, R25,		Element 1 Residents (R6, R25, and R11) ha comprehensive assessment of paassessment tool has been analyz updated and comprehensive care have been developed and implem Resident (R9) has been interview care plan is in place to encourage	nin. The ed and plans nented. ed and a	

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 3 of 73

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPLE	
		00296	B. WING		10/03/2014	
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO VER, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	develop a care plar residents (R9) who with hair care.  Findings include:  R31's care plan dat the use of Celexa (milligrams (mg) dai adjustment disorde of Ferrous Sulfate (twice daily to treat at R31's physician's or Ferrous Sulfate 324 physician's orders of 10 mg daily.  At 8:44 a.m. register Ferrous Sulfate and on the care plan.  R6 experienced concare plan did not an iminimize/reduce paranticipate her need manner. The care how to minimize ponon-pharmacologic R6's pain.  On 10/1/14, at 9:00 in a wheelchair in the cry with tears running the care plan in the cry with tears running the care in the cry with tears running the care plan in the cry with tears running the care in the	an for hair care for 1 of 4 routinely refused assistance and antidepressant) 10 ly for depressed mood and r, and did not address the use (an iron supplement) 324 mg a lack of red blood cells.  Indepression of the local cells and the did not address the use (an iron supplement) 324 mg a lack of red blood cells.  Indepression of the local cells and the did cells and the d		highest level of hair care acceptal resident. Resident (R31) has an care plan to address the medicati regimen. The same resident (R3 been evaluated for wheel chair pound the care plan has been updated. Element 2 All resident care plans have been reviewed and updated to reflect appropriate pain management, had choices, medication regimens, and chair positioning.  Element 3 The facility is care planning policy been updated as necessary and explanated as necessary and explanated to licensed numbers.  Element 4 20% of resident care plans will be weekly by the DON or designee for weeks, then monthly for 2 months thereafter quarterly. Variances with reported to the Administrator for immediate follow up and reviewed at least quarterly.	updated on 1) has positioning ted.  air care id wheel  y has education rsing  e audited or 4 s, and ill be	

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 4 of 73

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00296 B. WING	10/03/2014	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
were observed in the dining room as R6 cried holding her head. A few moments later nursing assistant (NA)-A walked up to R6 and escorted her to her room.  On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head.  On 10/2/14, at 9:10 a.m. NA-A stated R6 cried out in pain every day. NA-A stated R6 will complain while sitting in her wheelchair. NA-A reported R6 receives pain medications for pain management but she often has to wait until it is time for the next medication. NA-A stated R6 frequently watches the clock in her room waiting for the next pain medication.  On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 escplained the pain in her left leg wakes her at night and she often has to watch the clock to wait for her next dose of pain medications. R6 described the pain as a "toothache that never goes away." She stated the pain prevented her from participating in many of the activities in the facility because sometimes it was better in bed. R6 described the pain as being at an 8 or 9 on a 0-10 (10 worst) pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications.		

Minnesota Department of Health STATE FORM

5J6W11 If continuation sheet 5 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			COMPLETED	
		00296	В.	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115	10TH AVI	, ,	TATE, ZIP CODE  RTHEAST  36		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	stated she attempts her leg, but it usuall extended relief. Sh moments of pain re  On 10/2/14, at 10:1 (LPN)-B stated R6 "all of the time." Sh medications and wi the four hours to pa next pill. LPN-B stawish we could find so wish we could find so on 10/2/14, at 11:2 confirmed R6 expecare plan did not aconon-pharmacologic reduce/minimize R6 R25's care plan dat need to elevate leging Demedex (a diureting gain/edema, or the acetaminophen (Tythrough pain. Nor conon-pharmacologic other than ambulation R25's care plan lass would be rated on a since seed (PRN) in Interventions indicate ambulation and execution and execution in the seed of th	s to reposition R6 in bed on all y does not give R6 pain the stated R6 may have a felief, but it did not last long 0 a.m. licensed practical reported complaints of pain the stated R6 will request pain as before she can ask for atted R6 was uncomfortable something to giver her reliated R6 was uncomfortable something to give her reliated R6 was uncomfortable something to give her reliated R6 was uncomf	ew nurse in rain for the e, "I sef." d the nd s the of	2 560			
		at severe rheumatoid arth					

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 6 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00296		B. WING		10/0	03/2014
NAME OF	PROVIDER OR SUPPLIER	00200	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 10/0	7072014
HOMES	TEAD REHABILITATIO	N & LIVING CEN		AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII 'MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From particles patch every 72 hours every 3 days, Dema Percocet 5/325 mg acetaminophen 325 hours for minor or between scheduled not exceed 3000 m hours.  During interview on stated she had disconsisted she had disconsisted as he lay in hurts." Surveyor as anybody and she stated as she lay in hurts." Surveyor as anybody and she stated as she lay in hurts." Surveyor as anybody and she stated as she lay in hurts." Surveyor as anybody and she stated are busy." At 7 her legs hurt, "they them." At that time showed the surveyor and firm to the touch At 7:45 a.m. nursing observed assisting stated her groin/croso tight. At 7:50 a.m. transferred from toi NA-D stated, "Oh the dining room.  On 10/1/14, at 8:27 Percocet 5/325 mg at an 8.	rs 50 mcg/hr (hour) adex 10 mg every d 1 tablet every 4 hours are two tablets PR oreakthrough pain a Percocet doses if rg [acetaminophen] and present in both of he R indicated on 10/1, 5/325 mg. one tablet, and right and left be a moaning "oh reaked her if she had to atted, "No, they know are hard as a rock, R25 removed her cor her legs that appears the reak as swellen. R25 stated as she let to w/c, "oh my kroat darn arthritis."  atted her legs hurt arting." NA-D wheeled a.m. LPN-A gave Fareness and the save Fareness and LPN-A gave Fareness and LPN-A g	ay, Urs PRN, N every 4 nd give needed. Do total in 24  p.m. R25 er legs. /14, at 1:57 et was neel pain. a.m. R25 ny leg old w and all d both of just feel overs and eared shiny  was e day. R25 ed up and e nees hurt."  and added, ed her to	2 560			

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 7 of 73

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/03/2014	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	10.00.2011	
HOMES	TEAD REHABILITATIO	WISTIMUS CEN.	AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 560	Continued From page 7		2 560			
		0 a.m. RN-B verified the care s the items and should be on				
	the care plan did no	ontinued right knee pain and ot address interventions to hin other than to administer				
	alteration in comfor history of compress indicated R11 would on a verbal scale of pain medication. The administer medication monitor for effective possible side effect identify or address	ed 7/17/14, identified R11 had t related to pain secondary to sion fractures of her back and d verbally state pain was 2-3 f 0-10 after administration of he care plan directed staff to ions as ordered for pain and to eness of pain medications and s. The care plan did not R11's right knee/joint pain, nor narmacological interventions				
	her room, seated in had been having a knee and raised he began to rub it. The swollen. R11 stated the knee pain and s "but they don't last f 10/1/14, she was gi helped for a little bit up at night at times was "up a lot" until stated the pain med hours before her knalso stated she ask	4 a.m. R11 was observed in a recliner. R11 stated she lot of problems with her right r pant leg above her knee and e knee was observed to be d she was given pain pills for stated they lasted a little while forever." She stated that on ven cold packs and that t. R11 stated the pain kept her and the previous night she she finally got a pain pill. R11 dication lasted for about 4 nee began hurting again. R11 ed for a pain pill a couple of entified her pain right now at an				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 8 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7.1. 50.125.1.10.				
		00296	B. WING		10/0	3/2014	
NAME OF P	ROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
HOMEST	EAD REHABILITATIO	N & LIVING CENT	I AVENUE NO VER, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 8	2 560				
	On 10/02/2014, at 1 ambulating back too R11 was observed R11 stated her knew whirlpool bath.  On 10/02/2014, at 1 had pain daily and r since recently bump On 10/02/2014, at 1 had pain every day for the pain. NA-D of any non-pharmac relief of R11's pain that aggravated R1' indicated Scheduled day and could also her knee pain. LPN warm packs on her they had only done had been about a mad been used. LP packs had been effi warm packs when they had only done had been used. LP packs had been effi warm packs when they had only done had been used. LP packs had been effi warm packs when they had only done had just instructed her to elequate the medication.  On 10/02/2014, at 3 consultant RN confidence in the same relief to the same relief	10:02 a.m. R11 was observed ward her room after her bath. to be limping on her right leg. e felt much better after her  10:48 a.m. NA-B stated R11 may have had more pain lately ping her right knee.  10:55 a.m. NA-D stated R11 and received pain medication indicated she was not aware cological interventions for the nor was she aware of factors 1's pain. NA-D further mas mostly in her knees.  2:39 p.m. LPN-B stated R11 pain medication three times a have PRN pain medication for N-B indicated R11 had used legs previously, but stated so very occasionally, and it nonth since the warm packs PN-B indicated that the warm ective, and R11 had liked the used in the past. LPN-B I currently indicated she was thad a pain pill, they evate her legs and take it easy					

6899

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	
		00296	B. WING		10/0	3/2014
	ROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DRESS, CITY, S AVENUE NO ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	of assistance with here of assistance with here of assistance with here of assistance with here of assistance and seem of a care Area Assessment of a care Area Assessment of a care and seem of a care and	not address her routine refusal hair care.  ission Record dated 10/2/14, agnoses that included e, dementia with behavioral depressive disorder, is on one vertical half of the ropathy in diabetes (nerve ambness, loss of sensation in feet, legs and hands)  num Data Set (MDS) dated R9 had severe cognitive juired extensive assistance of	2 560			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO VER, MN 566	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 10	2 560			
	The care plan did nof hair care or identification minimize/reduce re					
		3:53 p.m. R9 was observed to r hair was observed to be				
	On 9/30/14, at 1:18 p.m. R9 observed resting in bed. Her hair was noted to be unclean.					
	On 10/01/2014, at 7:49 a.m. R9 was observed lying in bed. Her hair was observed to be unclean.					
	On 10/1/14, at 7:55 a.m. R9 stated she receives a bed bath. She stated she received a bed bath on 9/30/14, but did not know if her hair had been washed.					
	stated R9 usually re washed. NA-B indi mess it caused to vindicated R9 had re cap shampoo or dry would sometimes at the beauty shop who NA-D stated R9 wo weeks without wash	9:42 a.m. NA-B and NA-D efused to have her hair cated R9 does not like the wash her hair in bed. NA-D efused alternatives such as y shampoo. NA-B stated R9 ellow her hair to be washed in then she got up. NA-B and uld frequently go longer than 2 hing her hair. Both indicated or hair colored and would allow ed at that time.				
		11:55 a.m. NA-B indicated she nd she refused a hair wash.				
	supposed to have h confirmed R9's hair	1:47 p.m. RN-A stated R9 was ner hair washed weekly. RN-A was "grimy" on 9/30/14. s able to express her own				

6899

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DORESS, CITY, S AVENUE NO VER, MN 560	_		
(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
2 560	preferences and ne such care.  On 10/02/2014 at 8 confirmed the refus was not on R9's car have been.  On 10/02/2014, at 8 like to have her hair the mess it created her hair washed at like to have her hair she had felt weak la	ge 11 seds, and would often refuse 3:43 a.m. the interim DON all of hair care and grooming re plan, and verified it should 3:48 a.m. R9 stated she didn't r washed in bed, she didn't like r. R9 stated she liked to have the beauty shop,and would r colored. R9 further stated ately and hadn't wanted to to get up and get it done.	2 560			
2 565	The director of nurs staff to develop a car interventions for all director of nursing of compliance.  TIME PERIOD FOR (21) days.  MN Rule 4658.0408 Plan of Care; Use  Subp. 3. Use. A co	R CORRECTION: Twenty-one  Subp. 3 Comprehensive  Comprehensive plan of care  personnel involved in the	2 565			11/12/14
	care or the resident	•				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00296		B. WING			3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN	115 10TH	DRESS, CITY, S AVENUE NO ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 12			2 565			
	by: Based on observati review, the facility for 1 resident (R19) wanderguard, and for timely positionin	ent is not met as evi- on, interview and doc ailed to follow the car b) who required a 1 of 1 resident (R4) re g and incontinence o	cument e plan for eviewed		Element 1 A wander guard was placed on re- R19 who is identified as an eloper risk. Nurses are checking placem the wander guard every shift per t	ment ent of	
	Findings include:  R19's care plan dated 6/30/14, indicated R19 wore a wanderguard to prevent injury from unknowingly leaving the building.  On 9/30/14, at 9:05 a.m. the surveyor was unable to find the wanderguard bracelet on R19's ankles.  On 10/1/14, at 7:55 a.m. R19 was observed not to have the wanderguard bracelet on her ankles. At 9:15 a.m. registered nurse (RN)-A checked R19 for a wanderguard bracelet and verified she not wearing one.  On 10/1/14, at 8:53 a.m. RN-A verified the care plan was not followed regarding the use of the wanderguard.			Element 2 A baseline audit of all residents will elopement risks were assessed for placement of wander guards. All residents wander guard placement being checked by nursing ever shifted the MAR.	or nt is		
				Element 3 The policy was reviewed and update appropriate. Nursing staff were experienced in the policy and elopement precautions.  Element 4 The nurse on duty will assess all range who are elopement risks for wand placement every shift per the MAR DON/designee will monitor the MAR documentation of placement of the wander guard weekly x 4 weeks, the support of the	ducated nt risk residents ler guard R. The AR for e		
	to be turned and rewhen up in her whe every two hours.  On 10/1/14, at 7:05 at the dining room to	d 9/11/2014, indicate positioned every 1 1/sel chair, and offered a.m. R4 was observable. R4 was wheelesferred with a mechal25 a.m.	2 hours toileting ed sitting ed to the		monthly x 2 months and thereafte quarterly. Variances will be report Administrator for immediate follow reviewed at QAPI at least quarterly	r ed to the up and	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE  COMP.			
	00296				10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115 10	ADDRESS, CITY, TH AVENUE NO RIVER, MN 56	ORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	On 10/1/2014, at 9: (NA)-H stated R4 wat 6:30 a.m. and hat toileted since that til NA-H stated R4 wat toileted every 2 hour on 10/1/14, at 12:2 plan was not follow toileting.  The undated care printerdisciplinary teal implement a comprindividualized and of the resident.  SUGGESTED MET The director of nurse.	30 a.m. nursing assistant as placed in her wheel chair d not been repositioned or me (2 hours and 55 minutes s to be repositioned and	e end			
2 830	followed according monitoring program to assure ongoing a interventions in response of the property of the pro	to individualized needs. A could be established in ord and effective care plan conse to resident care needs? CORRECTION: Twenty or Subp. 1 Adequate and	2 830			11/12/14
	custodial care, and individual needs an	supervision based on d preferences as identified in resident assessment and				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S COMPLE			
	00296			B. WING		10/03	/2014
	HOMESTEAD REHABILITATION & LIVING CEN. 115 10TH			DRESS, CITY, S AVENUE NO ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	4658.0405. A nursi of bed as much as written order from t	scribed in parts 4658 ing home resident monossible unless ther he attending physicial in bed or the resident.	ust be out re is a an that the	2 830			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive assessment of pain, and failed to implement interventions in an attempt to manage chronic pain for 3 of 3 residents (R25, R6, R11) reviewed who experienced pain. Failure to alleviate pain resulted in actual harm for R25, R6 and R11. In addition, the facility failed to provide wheelchair positioning for 1 of 1 resident (R31) who had improper wheelchair positioning.			Element 1 Residents R25, R6 and R11 were immediately effectively treated for and monitored around the clock. Comprehensive pain assessments performed and analyzed. An interdisciplinary team form and ne regimen have been created to add both pharmacologic and non-pharmacologic interventions the individual resident s pain goal was evaluated and provided a charmeets positioning needs.	pain s were w dress co meet I. R31		
	on a regular basis of medications and with the pain. In addition interventions were alleviate pain.  R25's significant chindicated R25 was understood others, self-understood and wants both ver MDS indicated R25	ing moderate to sever despite receiving nare thout adequate assent, non-pharmacologic not implemented to hange MDS dated 7/1 cognitively impaired, had the ability to mad was able to expressibally and non-verball required supervisioning and was independent	cotic pain ssment of cal nelp 10/14, ke s ideas y. The		Element 2 A comprehensive pain assessmer performed on all residents in the fand care plans updated and imple to meet all resident pain goals included pain goals. All residents in wheel were screened for proper position.  Element 3 The pain protocol was updated to current standards of care. Moders severe pain levels will be address immediately. Regular use of PRN	acility emented luding blogic chairs ing.  reflect ate to ed	

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 15 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  COMPL					
		00296		B. WING		10/0	3/2014
	HOMESTEAD REHABILITATION & LIVING CEN. 115 10TH			DRESS, CITY, S AVENUE NO VER, MN 566		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	eating. The MDS al scheduled pain mer interventions, and h MDS identified diag arthritis, chronic particles attacks (TIA).  The 7/24/2014, Pair indicated R25 had a R25's care plan las rated her pain on a (PRN) medications Interventions indicated ambulation and execution of the pharmalogical addressed.  The 6/12/2014, Pair summary indicated Fentanyl (narcotic micrograms (mcg) revery 72 hours and medication to treat milligrams (mg) PR of 5 days. The asset had pain related to R25 participated in toilet and also ambulation and execution of the second pain related to R25 participated in toilet and also ambulation assessment indicated was adequate for pshould continue curing the following very well varied due to pain in neck from arthritis participated in the following very well varied due to pain in neck from arthritis participated in the following very well varied due to pain in neck from arthritis participated in the following very well varied due to pain in neck from arthritis participated in the following very well varied due to pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in neck from arthritis participated in the following very well varied for pain in the following very well v	so indicated R25 recedication, received non and pain occasionally. Inoses including: rheurin syndrome, osteopolase and transient ischarchitis and pain varied trevised 8/5/14, indicated R25 was to particated R25 was to particated R25 was to particated R25 was to particated R25 utilized a scheduled in the control of the c	-medical The matoid rosis, nemic  CAA) d.  ated R25 needed ated. ipate in ain. No  essment alled  ged otic ain) aily 4 out ted R25 arthritis, to the limen that staff  ated R25 distance	2 830	medications will be evaluated fappropriate pain regimen. Educated to nursing staff. Thereducated nursing staff on whee positioning.  Element 4 All residents will be evaluated faursing staff at least every shift DON or designee will monitor 2 MARs for excessive PRN use a moderate to severe pain levels weeks, then monthly for 2 monthereafter quarterly. DON or dononitor all residents in wheel cappropriate positioning daily x weekly x 3 weeks, then monthl months and thereafter quarterly will be reported to the Administ immediate follow up and review at least quarterly.	cation was apy el chair  or pain by t on going. 0% of and weekly x 4 ths, and esignee will chairs for 7 days, then y x 2 y. Variances rator for	

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00296				10/0	3/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	started on oxycodo tablet every four ho The 9/2/2014, phys increase of Fentany (previously 25 mcg) hours for 30 days. administration reco and assessment of R25's Fentanyl pate. The 9/15/14, physic her legs hurt and in	ician order indicated an yl (Duragesic) to 50 mcg patch and to change every 72. The electronic medication rd (EMAR) lacked monitoring the efficacy of the increase in ch.				
	her legs hurt and indicated R25 had 2 plus peripheral edema bilaterally which she'd had for a long time. The note indicated the edema was a little worse and more uncomfortable for her. The note also indicated R25 had severe deforming rheumatoid arthritis. The physician's plan indicated R25 had not previously utilized diuretics, that the elevation of her legs was not taking care of the edema, and that it had become symptomatic for her. Plan to get a baseline BMP (basic metabolic panel- lab work) and another one on Friday and start her on Demadex (diuretic) 10 mg every day and to monitor weights.					
	practical nurse (LPI complained of seve (evening), and that been given at 4:40 minimal relief after note indicated the rwas very swollen, filacked documentation	progress note by licensed N)-B indicated R25 had are left leg pain in the p.m. PRN Percocet 5/325 had p.m. and 10:30 p.m., with the 1st dose. The progress had noted R25's left leg rom foot to hip. The record ion of the effectiveness of the N that had been given to R25.				

6899

Minnesota Department of Health

AND DI AN OF CORRECTION IN INDENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
00296		B. WING		10/0	3/2014
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION	18 LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO (ER, MN 566	_		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
R25's current medica sodium (used to trea 25/ml (milliliters) inje patch every 72 hours every 3 days, Demac Percocet 5/325 mg 1 acetaminophen 325 hours for minor or br between scheduled finot exceed 3000 mg hours.  The EMAR dated 9/2 following:  -R25's PRN Percocet on average of 3 time times in one day, with administered.  -PRN Percocet was allower extremity discoursed.  -R25's PRN pain me of the 93 doses, "sor the 93 doses, not eff and 55 out of the 93 lacking on the medic.  During interview on 9 stated she had discoursed she had discoursed.  During interview on 9 stated she had discoursed she had discoursed she had discoursed she had discoursed.  During interview on 1 stated she left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the EMAR a.m. PRN Percocet 8 given due to left leg as Documentation on efforts and 55 out of the	ician's order report indicated ations included: methotrexate t severe rheumatoid arthritis) ction every 7 days, Fentanyl 50 mcg/hr (hour), change dex 10 mg every day, tablet every 4 hours PRN, mg two tablets PRN every 4 eakthrough pain and give Percocet doses if needed. Do [acetaminophen] total in 24 exthangled the ext had been used every day is a day and was up to 5 h a total of 93 doses extended fective 17 out mewhat effective" 10 out of ective 1 out of the 93 doses, doses the effectiveness was	2 830			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G:		E SURVEY PLETED	
		00296	B. WING _		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN' 115	REET ADDRESS, CITY 5 10TH AVENUE N ER RIVER, MN 5	IORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 830	anybody and she sistaff are busy." At 7 her legs hurt, "they them." At that time showed the survey and firm to the touch At 7:45 a.m. nursin observed assisting stated her groin/croso tight. At 7:50 a.m. transferred from toik nees hurt." NA-D is NA-D handed her astarted to put on the assistance. R25 stapants were too tigh pair of pants due to moaned in discomfeach pair of pants. R25 added, "Oh it is time (8:00 a.m.) R2 that morning she no because of her leg observed to notify the dining room.  On 10/1/14, at 8:27 Percocet 5/325 mg at an 8.  At 8:50 a.m. R25 has breakfast and at 9:0 pain pill. LPN-A staminutes ago and R	tated, "No, they know and 7:15 a.m. R25 stated both are hard as a rock, just f R25 removed her covers or her legs that appeared	n of eel and shiny  . R25 and  . R25 and  . R25 out on bad." that f but bed of the delay that for a bill 25 we the			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/0	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DDRESS, CITY, S' I AVENUE NOI VER, MN 566	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	in her legs. NA-D s difference if she ha not, R25 was alway At 12:55 p.m. R25 this morning for about "They [her legs] hur At 1:05 p.m. R25 to (DON) her legs hur	stated,"[the pain pills] helped but two hours." R25 added, rt, they hurt, they hurt!"  old the director of nursing t. At 1:07 p.m. LPN-A gave 1:5 mg. tablet for pain in her				
	tell if R25's pain pill don't ask R25 if the because that was "another pain pill." It to ask for another paid not inform her the morning of 10/1/14 have reported to he pain pill before gett "It has been very crestated R25 did not acetaminophen for due to the staff did	breakthrough pain probably not want R25 to exceed the ount of 3000 mg, since	r			
	doing terrible with hegs. LPN-B stated to help. LPN-B state R25 the PRN aceta	a.m. LPN-B stated R25 was her pain management for her the medications did not seem ed she had not been giving minophen for break through ow why they did not give it.				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 20 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ADED:	` '	E CONSTRUCTION		E SURVEY PLETED	
		00296	1	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN	STREET ADDR 115 10TH A'DEER RIVE	VENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	On 10/2/14, at 9:30 stated NA-D should regarding R25's parcares. RN-B verified 2-3 times a day and given on a regular by physician would be break through PRN given as directed by the staff could be do pain on a daily basicurrent pain medical were reporting that managed, the information to the DON.  On 10/2/14, at 11:2 PRN Percocet usual but then R25 would LPN-B stated last in Percocet around 2: R25 was asking for however, did not given LPN-B stated due to bumped up dose of concerned about he she did get up by home of the property of the	a.m. registered nursed have contacted LPN in and before starting d R25 had used PRN d she questioned if it spasis. RN-B stated the contacted and verified acetaminophen shouly the physician. RN-B oing some monitorings for the effectiveness ations. RN-B added if R25's pain was terrib mation needed to be all state, "Old Arthur hunight LPN-D gave R25 on a.m. and then 2 how another pain medical ve her anything.  To the fact R25 was or another pain medical ve her anything.  To the fact R25 was or another pain medical ve her anything.	e (RN)-B N-A a.m. Percocet should be e d the uld be stated g of R25's s of her staff ly relayed  R25's while rts." 5 a PRN burs later tion, a the eff were cause  RN stated the ded to be the /2/14, ilateral o see if nips- left	2 830			

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 21 of 73

Minnesota Department of Health

AND DI AN OF CODDECTION IDENTIFICATION NI IMPED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/0	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
HOMES	TEAD REHABILITATIO	N & I IVING CFN	AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	lower extremities, a mg every day.  R6 was experiencing which affected her a of daily living, withouthe pain and/or efficient medication. In additinterventions were nalleviate pain.  R6's annual MDS dintact cognition and assistance for all act MDS also indicated assessment period, level at a 5 on a 0 to assessment indicated to participate in day.  R6's Pain CAA date voiced complaints of scheduled pain medication for brea attributed to cerebra muscle spasms. The assisted her to take throughout the day.	ee times a day, ace wraps to nd to increase Demedex to 15 ag chronic pain on daily basis ability to participate in activities ut adequate assessment of eacy of the narcotic tion, non-pharmacological not implemented to help atted 3/3/14, indicated R6 had required extensive staff ctivities of daily living. The during the annual and R6 had reported her pain to 10 pain scale. The ed the pain limited R6's ability	2 830			
	R6's quarterly MDS R6 had intact cogni assistance with all a unable to ambulate diagnosis including diabetes mellitus ar	dated 9/3/14, also indicated tion, required extensive staff activities of daily living and was . The MDS indicated R6 had cerebral palsy, anxiety, and congestive heart failure. eated R6 suffered from				

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10	T ADDRESS, CITY, S OTH AVENUE NO R RIVER, MN 560	DRTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	frequent pain which participating in daily assessment period be at a 6 on a 0-10  R6's care plan date alteration in comfor	n prevented her from a ctivities. During the R6 had reported her pain pain scale.  and 6/4/14, identified an trelated to numbness/tingli	ng			
	and muscle spastic palsy. The plan dir needs and respond plan did not direct s potential leg pain a	dary to carpal tunnel syndro ity secondary to cerebral ected staff to anticipate her in a timely manner. The cast staff on how to minimize and it did not include al interventions to minimize	are			
	biggest problem wa note also indicated the clock and askin medications. The p Fentanyl patch for I to monitor for pain of the pain medication	hysician had initiated use on R6 and indicated the staff we control and anxiety related the staff was. The physician identified make pain medication	ne ng f a ere			
	and 8/12/14, for ar progress notes did a visit on 9/5/14, th	e physician on 8/5/14, 8/8/14 acute infection, those not address R6's pain. Dur the physician noted, "Will aurrent pain medications, wh well for her."	ring			
	included Baclofen times a day, Gaba treat nerve pain) 30	er Report dated 9/5/14, (muscle relaxer) 10 mg thre pentin (medication used to 00 mg three times a day, an gth 500 mg one tablet every	d			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) D/ A. BUILDING:			
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 1	ET ADDRESS, CITY, S 10TH AVENUE NO R RIVER, MN 560	DRTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	four hours as needd 7/6/14, the physicia (medicated pain pa changed every three. The facility complete R6 on 8/30/14 - 9/3 3/31/14, and 11/27/collection tools indicated in the collection tools indicated in the summary repermedications, indicated pain daily and directly as needed pain occupational and please of the curate in the collection on 7/6/14, was effered. Review of the residence in indicated the collection in Tylenol promition on Tylenol promition in Tylenol p	ed for pain. In addition, on in had added Fentanyl tch) 25 mcg/ hour to be e days.  The da Pain Data Collection of the ted a review of R6's pated the current pain ted R6 had voiced concerned at the ted staff to assist with commedications, repositioning the ted the ted and the ted	ne pain. ns of lifort l			
	well to repositioning non-pharmacologic	g and massage as				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	1:30 a.m. Non-pha used before resider light massage, repowith the affected leg -8/17/14, at 5:11 a.r time. No further fol - 8/28/14, at 6:41 a.mg for leg pain. The pain.  On 10/1/14, at 9:00 in a wheelchair in the cry with tears running staff. She stated, were observed in the holding her head. A walked up to R6 an At 9:15 a.m. R6 was On 10/2/14, at 9:00 in a wheelchair in the cry, "Ey, ey, ey, oh looking for staff me my goodness" as side At 9:05 a.m. NA-A severy day. She state sitting in her wheeld received pain medication. S watched the clock in pain medication.	rmacological interventions at was due for PRN included osition and range of motion of the stated Tylenol one low up was noted.  The R6 requested Tylenol 500 are note lacked follow up to the lacked follow up to the a.m. R6 was observed seated the dining room. R6 began to one down her face calling out to Oh, oh oh." No staff members are dining room as R6 cried A few moments later NA-A descorted her to her room. In sobserved resting in bed.  The A1 was observed seated the dining room. R6 began to that leg. T6 turned her head mbers and began to cry that leg. T6 turned her head mbers and began to cry the shook her head.  The A2 wheeled R6 to her room.  The A3 wheeled R6 to her room.  The A4 reported R6 cations for pain management of wait until it is time for the he stated R6 frequently in her room waiting for the next.				
		a.m. R6 stated she her left leg every day and will				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 25 of 73

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00296	B. WING		10/03/2014	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 10/0	3/2014
	TEAD REHABILITATIO	115 10TH	AVENUE NO	•		
	I	DEER RIV	/ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 25	2 830			
	care of the pain for the pain in her left leads of pain medica as a "toothache that stated the pain prevent many of the activities sometimes it was better if at an 8 or 9 on a 0-she has to watch the receiving her pain in the stated she attempts her leg, but it usually	e explained the Tylenol takes about an hour. R6 explained eg woke her at night and she the clock to wait for her next ation. R6 described the pain at never goes away." She wented her from participating in es in the facility because etter in the chair and other in bed. R6 described the pain 10 pain scale daily. R6 stated he clock to make sure she is medications.  10 a.m. NA-D stated R6 her left leg every day. She is to reposition R6 in bed or rub ly does not give R6 extended R6 may have a few moments				
	the pain to the nurs  Review of the EMA	did not last long. She reports es.  R revealed the following				
	information: 7/1/14 - 7/31/14, R6 PRN Tylenol.	6 had received 90 doses of				
	7/1/14 - 7/31/14, R6 PRN Tylenol.	6 had received 90 doses of				
	8/1/14 - 8/31/13, R6 Tylenol 500 mg.	6 received 81 doses of PRN				
	9/1//14 - 9/30/14, R Tylenol 500 mg.	6 received 98 doses of PRN				
	10/1/14- 10/2/14, R PRN Tylenol 500 m	6 had received 6 doses of g.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED		
		00296		B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN	115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE		
2 830	The reason documented for the medication was "pain" or "leg pain." The medication was noted to be "effective" or "somewhat effective."  On 10/2/14, at 10:10 a.m. LPN-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to giver her relief." LPN-B stated when she would administer R6's pain medications she followed up with R6 by visually looking at her. She stated if the nurse were to ask her how her pain was, she would just ask for more medications. LPN-B added if R6 looked like she was not in pain, they write effective or somewhat effective. She confirmed she did not discuss pain relief with R6.		2 830				
	with the interim DO interim DON stated pain daily. The two record and were un the staff had compl assessment of R6's determine if the Fei	0 a.m. R6's pain was N and the consultan she was aware R6 RNs reviewed R6's able to find indication eted a comprehension pain and were unable than yl which had be affective medication in the standard was shown to be able to the standard was shown to be a shown to be able to the standard was shown to be able to be able to the standard was shown to be able to be a	t RN. The expressed clinical on in which we ble to en added				
	confirmed R6 experiments to determine the extra the facility had not experiment. She confirmed in the confir	0 a.m. the consultant rienced pain daily and rely reassessed by the tent of the pain. She exhausted resources firmed R6 had not conacological interventishe continued to expension and consultant relationships and the continued to expension and consultant relationships are relationships and consultant relationships and consultant relationships and consultant relationships and consultant relationships are relationships and consultant relationships and consultant relationships are relationships and consultant relationships and consultant relationships and consultant relationships are relationships and consultant relationships and consultant relationships are relationships and consultant relationships are relationships and consultant relationships and consultant relationships are relationships and consultant relatio	nd had not he nurses e stated s to reduce consistently tions to				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 27 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER TEAD REHABILITATIO	N & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	medications for the aware she was utilized per month. At that asked to review R6 determine a timeling in the past 6 month. On 10/3/14, at 8:50 she had interviewed expressed continue not find it helpful to determine what had but felt it was better forward and treat R provided a Patient 0 dated 10/3/14, whice expressed daily pain.  R11 was experience chronic pain on dail ability to participate without adequate as efficacy of the narconic implementation of r interventions to help R11's Physician Ore 9/3/14-10/3/14, indivincluded osteoporos	s aware R6 was utilizing PRN treatment of pain but was not zing over 70 PRN medications time the RN consultant was 's medication regimen to e of pain medication changes s.  a.m. the consultant RN stated d R6 and confirmed R6 ed pain. She stated she did review R6's record to d been attempted in the past, to take the time and move 6's pain. The consultant RN comfort Assessment Guide th confirmed R6 continued to the confirmed R6 continued to the pain and / or		DETICIENCY)		
	leg osteoarthritis (d the cartilage), chror and Wegener's gra inflammation of the R11's significant ch	more likely to fracture), lower egenerative arthritis affecting nic pain, restless leg syndrome nulomatosis (causes blood vessels).  ange MDS dated 8/11/14, severe cognitive impairment				

6899

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		COMPLETED		
		00296	B. WING		10/0	10/03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
HOMES	TEAD REHABILITATIO	N & I IVING CEN	TH AVENUE NO RIVER, MN 560	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 830	and required extens locomotion on and personal hygiene at staff for bed mobility and corridor and too indicated R11 receipain medication and for pain. The MDS her pain as moderal interfere with daily a sleep at night. The received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical therapy (OT) servi	sive assistance of one staff for the unit, dressing and and limited assistance of one y, transfer, ambulating in root let use. The MDS also wed scheduled and as needed non-medication interventio also indicated R11 reported te and frequent but it did not activities or make it difficult to MDS further indicated R11 herapy (PT) and occupationales and received active range storative nursing services.  S dated 7/12/14, indicated R itive impairment and require of one staff for bed mobility, and toilet use and supervisional also indicted R11 received heeded pain medications and reported her pain as moderadid not interfere with daily difficult to sleep at night. The did not receive PT, OT or	m ed ans of the state of the st				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 29 of 73

(X3) DATE SURVEY COMPLETED

00296

B. WING \_\_\_

10/03/2014

NAME OF I			STATE, ZIP CODE	
HOMEST	FAD REHARII ITATION & LIVING CEN	AVENUE NO 'ER, MN 566		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29 pain. Finally, the CAA indicated R11's pain was chronic in nature and required scheduled and PRN analgesics to maintain optimal comfort level.	2 830		
	R11's Activities of Daily Living / Functional Rehabilitation CAA dated 8/23/14, indicated R11 remained at risk for further on going decline due to progression of chronic disease processes resulting in a past history of falls, chronic pain and functional urinary incontinence. The CAA indicated R11 had returned to baseline since hospitalization for pneumonia and indicated staff was to continue to assist with ADL and mobility as needed and report changes in ability and tolerance. The CAA also indicated anticipation of on going fluctuation of physical function and tolerance based on potential exacerbation of chronic disease processes.			
	R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and possible side effects. The care plan did not identify or address R11's knee/joint pain, nor did it identify non-pharmacological interventions for pain.			
	Review of R11's medical record revealed the following history regarding the ongoing management of R11's knee pain:			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DDRESS, CITY, ST AVENUE NOF VER, MN 5663	RTHEAST		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	The RN Assessment the Pain Data Colled 1/12/14, indicated Fassessment period Lortab (hydrocodor pain reliever for more more three times dail anesthetic) to lower R11 could also have breakthrough paint any during the asses Non-medication into repositioning, exercivisits. R11's pain we with medication and	nt Summary dated 1/13/14, on ection form dated 1/8/14, to R11 had denied pain during the and R11 received scheduled ne-acetaminophen)(a narcotic oderate to severe pain) 10-500 by and Lidoderm patch (a local r back daily. It also identified to PRN Lortab for though she had not received essment period. erventions to pain included cise/ROM, activities and 1:1 was assessed as controlled d interventions at that time.				
	identified R11 had a pain with weight be identified R11 had a disease and R11 had previous that had h progress note furth	ress note dated 2/25/14, a chief complaint of right knee earing for 1 week. It also a history of degenerative joint ad last had an injection months selped "for a long time." The er indicated R11 received a to her right knee at the visit.	6			
	indicated the visit with knee pain and iden of that pain with the very long. R11 con weight bearing and bed at times. The R11 had been takin PRN basis. R11 refor a while but wore assessment identifications.	ress note dated 3/10/14, was for follow up on R11's right tified R11 reported some relief e cortisone injection but not for a tinued to report pain with stated it hurt even while in progress note also identified and Lortab on a scheduled and eported the medication worked e off. The physician ied right knee pain with disease, transient response to ction with constipation likely				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 31 of 73

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	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10T	DDRESS, CITY, S H AVENUE NO IVER, MN 566	RTHEAST	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	related to activity ar progress note ident to increase R11's la Fentanyl patch from 12.5 micrograms (nher current dose of hydrocodone.  The physician's tele included the followin Norco (hydrocodon pain reliever for mopain) 5-325 mg one as needed, trial of F	ge 31 and pain medications. The ified the physician's plan was exatives and switch her to a scheduled hydrocodone, ance) per hours equivalent to 30-40 mg per day of ephone orders dated 3/10/14, and change Lortab 10-500 to e-acetaminophen)(a narcotic derate to moderately severe by mouth three times a day fentanyl patch 12.5 mcg and discontinue scheduled	2 830			
	the Pain Data Colle R11 had reported p look back period an scheduled pain med medication frequen summary also indic ambulate and be as this time a knee bradiscontinued due difurther identified R1 medication change  The Memo To Phys R11 was needing to times a day nearly of pain. The memo be given more ofter The physician responses	scomfort. The summary				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED		
		00296	B. WING		10/	10/03/2014	
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566		·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 830	twice a day PRN form.  The Memo to Physical R11 appeared to be and questioned conthey could consider of Vicodin (hydrocomorphine versus Fer R11's family had cowanted the physicial (time-released mort twelve hours for chiral R11's Norco back to and twice a day as response dated 6/1 she responds to include a response to include the physicial response to the responds to include the responds to include the responds to include the responding to the respective to the responding to the responding to the responding to	r breakthrough pain.  ician dated 6/1/14, identified a more drowsy and lethargic offusion. The memo asked if going back to increased dose done-acetaminophen) or oral entanyl. The memo indicated oncerns with Fentanyl and an to consider MS Contin phine usually taken every ronic pain) and an increase of to 10-325 [sic] four times a day needed. The physician 2/14, indicated "we'll see how	2 830				
	had been some corconfusion and there about switching back. The note further ide PRN Norco in the pFentanyl. The physiconcern for intermit he would hold off or time. The impressi	check about increasing to had been some discussion ock from Fentanyl to Norco. The sentified R11 had only taken 3 that 2 weeks while on the sician's impression was some attent confusion and indicated on the Fentanyl change at that on also indicated a possible to physician increased her					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) D.  A. BUILDING:			
		00296	B. WING		10/03	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115 10	T ADDRESS, CITY, OTH AVENUE NO R RIVER, MN 560	DRTHEAST	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	The Nursing Home R11's family was vestatus might be relaspecifically Fentany indicated he felt R were possibly relaterelated to her vision physician's plan warestless leg syndromaticated the road if R11 did Other options identificated the road if R11 did Other options identificated the road if R11 did Other options identificated the Pain Data Colletonic Included decrease day and hold Fenta The RN Assessmenthe Pain Data Colletonic Included the P	Note dated 7/8/14, indicated by concerned her decline in ated to medications, vi. The physician impression and status changes and to depression and likely and hearing loss. The is to lower gabapentin (for me) from four times a day to did R11's Fentanyl. The morphine was an option dowell off of the hydrocodone ified were discontinuation oner or increase or decrease dephone Orders dated 7/8/1 gabapentin to 300 mg twice nyl patch trial for one week and Summary dated 7/14/14, action form dated 7/8/14 R11 reported moderate pain the physician was trying to old and symptoms of confusione current pain medication ted they would continue to cian for pain control. The totel identify non-pharmacological status in the physician control. The totel identify non-pharmacological controls in the physician was trying to control. The totel identify non-pharmacological controls in the physician control. The totel identify non-pharmacological controls in the controls in the physician controls.	n  Down  f  of  4,  c  on  n	DEFICIENCY)		
		ephone Orders dated 7/15/ pentin and discontinued	14,			
	The Nursing Home	Note dated 7/29/14, indicate	ted			

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 34 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00296	B. WING		10/0	3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOMEST	EAD REHABILITATIO	N & LIVING CEN	AVENUE NO ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	to pain, delirium, he physician's impress vertebral compress. The physician's pla wondering about m indicated he was co for their advice. His would not change r shortness of breath examination) was examination) was examination) was examination) was examination was examinated. The facility completes R11 was hospitalized 8/4/14 for pneumor.  The facility completes R11 on 8/5/14 - 8/9 summary of the data 8/13/14, identified for during the assessment examination assessment summ non-pharmacologic.  The Physician Orde 9/3/14-10/3/14, includes a day (sched tab twice a day PRI 500 mg 1 tab every report also included.	arding family concerns related earing and intake issues. The sion included pain issues with ion fractures and arthritis. In identified R11's family was orphine. The physician ensidering a referral to hospice is plan further indicated he inedications until R11's in (identified upon physician evaluated.  The RN assessment it is collection for collection completed on R11 had complained of pain inent period. The RN repeated edication regimen and in was rated as mild and the iss meeting R11's needs. The ary did not address all interventions for pain.	2 830			

Minnesota Department of Health

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		
		00296		B. WING		10/	03/2014
	PROVIDER OR SUPPLIER FEAD REHABILITATION	ON & LIVING CEN	115 10TH	DRESS, CITY, S AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	The Nursing Home R11 was seen by the knee pain. R11 report The nurse practition alternate heat and medications on the administration records tolerate.  R11's Medication A 8/8/14 - 10/3/14 revolution and the administered early days.  -Norco 5-325 m dose) was given early days.  -Norco 5-325 m dose) was given early days.  R11's PRN Medication A 8/25, 9/12, 9/22, 9/10/2, and 10/3 and (11 doses).  R11's PRN Medication A 8/8/14-10/3/14 revolution and the second pain in knees or given between the a.m. 4 doses were	Note dated 10/1/14, ne nurse practitioner foorted discomfort with perise plan was to applice, continue with pair MAR (medication and participate in dministration History ealed: sive patch 5% was at R11's request 30 cm g three times a day (so arly for the morning do 25, 9/26, 9/29, 9/30, for the afternoon dos tions Administration Healed:  g 1 tab twice a day Pon 29 of 57 days for collegs. 24 of 31 doses thours of 12:55 a.m. a given between the homeonic ported to the second s	for right in walking. Ily ice or in activities dated of 57 scheduled ose on 10/1, se on 9/9 History  RN, 32 complaints is were and 4:52 ours of	2 830			
	between the hours The medications w somewhat effective 9/28 which was ass R11's next schedul earlyacetaminopher as needed was give	p.m. and 3 doses we of 11:01 p.m. and 11: ere assessed to be except for one dose sessed to be not effected dose of Norco was 500 mg 1 tab every en once on 8/8, 8/30, es on 10/2 for complements.	:31 p.m. ffective or given on ctive and s given 6 hours and 9/3				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/03	/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	•	
HOMEST	TEAD REHABILITATIO	N & I IVING CFN	AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From page 36 pain in knees or legs. The medications were assessed to be effective					
	R11's Treatment Administration History 8/8/14-10/3/14 revealed: -Heat or ice to right knee for comfort as needed for intervals of 10 minutes was not documented on the treatment record during this time period.					
	The resident progress note dated 10/1/14, at 11:23 p.m. indicated an ice pack was applied to R11's right knee two times during the shift. R11 stated, "It feels better" however, within 1-2 hours complained of breakthrough pain.					
	On 10/2/14, at 9:04 a.m. R11 was observed in her room seated in a recliner. R11 stated she had been having a lot of problems with her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and that they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs, as well, and that helped for a little bit. R11 stated the pain kept her up at night at times and that the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asks for a pain pill a couple of times a day and identified her pain at that time at an 8 out of 10. R11 stated she also received cortisone shots from the physician and they lasted for about a month but the pain always came back. R11 further stated she was due for her bath today and the whirlpool tub also felt good					

Minnesota Department of Health

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/0	10/03/2014	
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115 10TH	DDRESS, CITY, ST AVENUE NOI VER, MN 5663	RTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 830	2 830 Continued From page 37						
	ambulating down the from her room to the	9:36 a.m. R11 was observed the hall with wheeled walker to bath room. Her gait was observed to favor her right					
	On 10/02/2014, at 10:02 a.m. R11 was observed ambulating back toward her room after her bath. R11 was observed to be limping on her right leg. R11 stated her knee felt much better after her whirlpool bath.  On 10/2/14, at 10:43 a.m. R11 was observed seated in her room in a recliner with a wheeled walker in front of her chair. R11 stated the pain limited her activities during the day and prevented her from joining in. She stated, "I just can't do it." R11 stated her knee currently still ached and was a 7 out of 10 on a 1 to 10 pain scale. R11 stated her knee hurt all the time but it was alright if she sat "absolutely still." R11 further indicated walking made her knee feel worse.						
	had pain daily and usince recently bumplindicated R11 would felt up to it and attenursing] three times	10:48 a.m. NA-B stated R11 may have had more pain lately bing her right knee. NA-B d go to some activities if she nded therapy [restorative is a week and would tell them if ered her too much so they rcises on that leg.					
		10:55 a.m. NA-D stated R11 and received pain medication					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
00296		B. WING		10/0	3/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HOMESTEAD REHABILITATION & LIVING CEN		AVENUE NO ER, MN 566			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
for the pain. NA-D indicated she was not of any non-pharmacological intervention relief of R11's pain nor was she aware of that aggravated R11's pain. NA-D stated spent most of her time in her room and out for meals or a bath. NA-D also state family used to bring her out to the commit to visit and have coffee, however they not did this when they visited. NA-D further R11's pain was mostly in her knees.  On 10/02/14, at 11:05 a.m. NA-C stated worked with R11 with restorative nursing exercises to both upper and lower extre NA-C confirmed R11 had pain in her right Review of the restorative nursing sheets August 2014, and September 2014, revehad not refused exercises to the right lowextremity.  On 10/02/2014, at 2:39 p.m. licensed pinurse LPN-B stated R11 received sched medication three times a day and could PRN pain medication for her knee pain. stated if R11 asked for extra pain medication was usually needed on the night shift bu occasionally given during the day. LPN-PRN Norco was usually given. LPN-B sidd not specifically ask R11 how effective medication was or asked R11 to rate her using the 1-10 pain scale after medication given. LPN-B stated sometimes asking resident about pain medication would provided the pain medication would proven them to ask for additional medication. Listed instead she would simply observe effectiveness or have general conversation.	s for the f factors d R11 only came ed R11's non area o longer indicated she emities. In knee. It is for ealed R11 wer oractical duled pain also have She ation, it it was estated tated she e the pain on was a compt PN-B e for ion with	2 830			

6899

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00296		B. WING			10/03/2014	
	PROVIDER OR SUPPLIER	N & LIVING CEN	115 10TH	DRESS, CITY, S AVENUE NO ER, MN 566		·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
2 830	very occasionally are since the warm pace indicated that the wand R11 had liked to the past. When asl warm or cold packs stated "sometimes indicated that curre in pain and had just instructed her to eleuntil the medication stated R11 stayed in came out occasional came out occasional came out occasional that is a consultant RN confinates been used as intervention for R11 should have been rebaseline functional on 10/3/13, at 8:55 provided a Patient (dated 10/3/14 which	stated they had only ond it had been about a less had been used. Liver packs had been warm packs when ked why they stopped for R11's knee pain, you get complacent". Intly if R11 indicated slate had a pain pill, they evate her legs and tak worked. Additionally in her room quite a bit,	a month PN-B effective used in used LPN-B he was e it easy , LPN-B , but  I and should al s pain return to alization.  RN Guide nued to	2 830				
	directed staff to ass and provide optima control plan which we the resident, family team. The policy di resident's pain, dev pharmacological interessions	ed Pain Assessment Faces the resident's pail comfort through a pail vas mutually establish and members of the lifected staff to assesselop pharmacological erventions to reduce to bysician of any unrelimes.	n level ain ned with health the and non the pain					

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 40 of 73

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 40	2 830			
	R31's admission M R31 was cognitively wheelchair locomot non-ambulatory. R3 indicated R31 had a foot, was non- weig	DS dated 8/23/14, indicated y intact, was independent with ion, transferring and was 31's Fall CAA dated 8/23/14, a puncture wound on her left the bearing and could safely				
	transfer self from the bed to the wheelchair and back.  On 9/29/14, at 6:10 p.m. R31 was observed in her wheelchair self propelling with her hands. R31's feet were observed dangling unsupported about eight inches from the floor. There were not leg rests observed on the wheelchair.  On 9/30/14, at 8:46 a.m. R31 stated they did not provide her with wheelchair leg rests.  At 2:26 p.m. R31 was observed self propelling her wheelchair with her hands. Her left foot was in a walking boot and her right foot was about eight inches from the floor.					
	At 2:56 p.m. R31 w herself in the wheel was able to use her walking boot to help her right foot were	as observed self propelling lchair back to her room. R31 relft foot that was in the with propelling. R31's toes of observed to touch the floor. In not equipped with leg rests.				
	at a table playing a	as observed in her wheelchair game. Her right heel ted and dangling about eight				

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 501251110.			
		00296	B. WING		10/0	3/2014
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
HOMEST	EAD REHABILITATIO	IN X I IVING CEN	VER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 41	2 830			
	inches from the floo	or.				
	her wheelchair. R3 her left foot dressin R31's feet were obtangling about eight At 8:20 a.m. registed was admitted in a vineither physical the therapy (OT) had significantly was so independent wheelchair with her not noticed that R3 at 11:20 a.m. R31 shad was equipped was too wide for her this time OT-A stated OT-A stated her fee floor. R31 stated ship propel the wheelch want her feet to day OT-A stated he wood other words.	a.m. R31 was observed in 1 had a blue surgical bootie on 1 and a sock on her right foot. served unsupported and 1 inches from the floor.  Bered nurse (RN)-A stated R31 wheelchair. RN-A stated erapy (PT) or occupational seen R31. RN-A stated R31 int with self propelling her rhands. RN-A stated she had 1's feet did not touch the floor. Stated the first wheelchair she with leg rests and that chair er to get into the bathroom. At ed R31 was up "way too high." et were eight inches from the ne only used her hands to air. OT-A told R31 they did not ngle from the wheelchair. uld make wheelchair oper wheelchair positioning.				
	wheelchair was too (FM)-A found this c	stated since her first wide for her, family member current wheelchair in the o her to use about two weeks				
	stated if she were thave proper wheeld	a.m. nursing assistant (NA)-Co see a resident that did not chair positioning she would ated she had not worked for				
	At 9:17 a.m. the co	nsulting registered nurse (RN)				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 42 of 73

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00296		B. WING		10/0	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOMEST	TEAD REHABILITATION	ON & LIVING CEN	AVENUE NO 'ER, MN 566			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	age 42	2 830			
	stated there was not a policy related to proper wheelchair positioning.					
	The director of nurs and revise the polic pain and pain mana provided to all of th system could be es	THOD OF CORRECTION: ses or designee could review by and procedures related to agement. Education could be a involved staff members. A stablished to provide ongoing tion to all involved parties.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
2 900	MN Rule 4658.052	5 Subp. 3 Rehab - Pressure	2 900			11/12/14
	Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:					
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	This MN Requirem by:	ent is not met as evidenced				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED		
	00296		B. WING		10/03/2014	
	N & LIVING CEN	115 10TH	AVENUE NO	DRTHEAST		
(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Based on observatireview, the facility faidentified at risk for assistance with rep the development of resident (R4) in the Findings include:  R4's diagnoses include:  R4's diagnoses includerebral palsy, strothe electronic medic (EMAR).  The quarterly Minim 9/6/2014, indicated required extensive mobility, transfers, amobility, t	on, interview and docailed to ensure a resipressure ulcers receositioning in order to pressure ulcers for 1 sample.  uded a multiple sclerke, and diabetes, acceptation administration administration and was non ambulated. R4 was at risk for pressure ulcers also indicated R4 was due to incontinence and was up in her was when up in her was using cushion in her was unit and cushion in her was un	dent eived prevent of 1  rosis, cording to record  dated pairment, red tory. The ressure  as at risk and  d R4 was purs while theel chair plan R4 wheel	2 900	and the pressure ulcer prevention plan was updated to reflect currer standards of care. The resident r at base line without skin breakdov  Element 2 All residents at risk for skin break were reassessed for bed, wheeled general positioning and tissue told The care plans were updated as necessary and implemented/communicated per k kiosks throughout the facility.  Element 3 Pressure ulcer prevention protocoupdated as appropriate and educanursing staff.  Element 4 Residents dependent for bed whe and general positioning will be more for repositioning by the nurse on a daily. The DON/designee will aud x 4 weeks, then monthly x 2 mont thereafter quarterly. Variances wireported to the Administrator for	care at emains vn.  down hair,and erance.  POC  I was ated to  elchair, hitored luty lit weekly hs and ll be	
	PROVIDER OR SUPPLIER  FEAD REHABILITATION  SUMMARY STA (EACH DEFICIENCY) REGULATORY OR LE  Continued From pa  Based on observatire review, the facility faidentified at risk for assistance with repthe development of resident (R4) in the  Findings include:  R4's diagnoses include:  The quarterly Minim 9/6/2014, indicated required extensive amobility, transfers, amobility, transf	ODE CORRECTION  OD296  PROVIDER OR SUPPLIER  TEAD REHABILITATION & LIVING CENT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL DEFICIENCY AND ALL DEFIC	OF CORRECTION  O0296  PROVIDER OR SUPPLIER  TEAD REHABILITATION & LIVING CEN:  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 43  Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received assistance with repositioning in order to prevent the development of pressure ulcers for 1 of 1 resident (R4) in the sample.  Findings include:  R4's diagnoses included a multiple sclerosis, cerebral palsy, stroke, and diabetes, according to the electronic medication administration record (EMAR).  The quarterly Minimum Data Set (MDS) dated 9/6/2014, indicated R4 had cognitive impairment, required extensive assist from staff for bed mobility, transfers, and was non ambulatory. The MDS also indicated R4 was at risk for pressure ulcers.  The 3/6/14, Pressure Ulcer Care Area Assessment (CAA) also indicated R4 was at risk for pressure ulcers due to incontinence and non-ambulatory.  The care plan dated 9/11/2014, indicated R4 was to be turned and repositioned every 3 hours while in bed and 1 1/2 hours when up in her wheel chair due to risk for pressure ulcers. The care plan R4 had a pressure reducing cushion in her wheel chair.  The 9/17/14, Braden Tissue Tolerance assessment indicated R4 was at risk for pressure	OF CORRECTION  OD296  B. WING	OPPOVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636  SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DESCRIPTION AS A USUAL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 43  Description of the development of pressure ulcers received assistance with repositioning in order to prevent the development of pressure ulcers for 1 of 1 resident (R4) in the sample.  Findings include:  R4's diagnoses included a multiple sclerosis, cerebral palsy, stroke, and diabetes, according to the electronic medication administration record (EMAR).  The quarterly Minimum Data Set (MDS) dated 9/6/2014, indicated R4 had cognitive impairment, required extensive assist from staff for bed mobility, transfers, and was non ambulatory. The MDS also indicated R4 was at risk for pressure ulcers for bed monibility, transfers, and was non ambulatory. The MDS also indicated R4 was at risk for pressure ulcers on claily. The DON/designee will aud x 4 weeks, then monthly x 2 monthly and pressure plan R4 had a pressure educing cushion in her wheel chair due to risk for pressure ulcers. The care plan R4 had a pressure reducing cushion in her wheel chair due to risk for pressure ulcers. The care plan R4 had a pressure reducing cushion in her wheel chair.	ODE CORRECTION ODGES OF SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST  DEER RIVER, MN 56636   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAGE OF

6899

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00296	B. WING		10/0	10/03/2014	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
HOMES	TEAD REHABILITATIO	N & I IVING CEN	AVENUE NO ER, MN 566	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 900	On 10/1/14, at 7:05 in the dining room a son stated she had came to see her at 8:50 a.m., R4 was of the table in the dining finished her breakfawheeled to the bath toilet. R4's skin to the intact with slight red.  On 10/1/2014, at 9: surveyor, NA-H state wheel chair at 6:30 repositioned or toile and 55 minutes with stated R4 was to be every 2 hours.  On 10/1/14, at 12:2 (RN)-A verified R4 very 2 hours while in hear plan was not for SUGGESTED MET The director of nursinterdisciplinary tearisk for pressure so prevent pressure so promote healing. Tassign the Quality Aprovide on-going meare to residents to	a.m. R4 was observed sitting at the table. At 7:30 a.m. R4's been up in the chair when he 6:45 a.m. From 7:50 a.m. to observed to continue sitting at any room. At 8:50 a.m. R4 was arroom and transferred to the ne buttocks was observed dness.  30 a.m. when asked by ted R4 was placed in her a.m. and had not been eted since that time (2 hours nout repositioning). NA-H e repositioned and toileted  0 p.m. registered nurse was to be repositioned every 1 er wheel chair. Adding R4's followed.  CHOD OF CORRECTION: sing could assign the am to review all residents at ores to assure they are sary treatment/services to ones from developing and to the director of nursing could assurance Committee to onitoring of the delivery of ensure that pressure sores ass the resident's clinical	2 900				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	OATE SURVEY OMPLETED	
		00296	B. WING		10/03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DDRESS, CITY, I I AVENUE NO VER, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From pa	ge 45	2 900		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes		2 930		11/12/14
	and feeding syringes. Based o	ric tubes, gastrostomy tubes, n the comprehensive resident sing home must ensure that:			
	B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.				
	by: Based on observati review, the facility for medications via gas individually with app 1 residents (R33) with medications	ent is not met as evidenced on, interview, and document ailed to administer strostomy tube (G-tube) propriate water flushes for 1 of the received G-tube		Element 1 The nurse who did not flush the G-tube with water between individual medicatio was educated regarding the correct pol regarding flushing with water between individual medications and return demonstration was verified.	
	post concussion sy (creation of an artifi	der Report dated ntified diagnoses that included ndrome and gastrostomy cial external opening into the nal support or gastrointestinal	1	Element 2 All residents with G-tubes were assess during medication pass for correct metl per policy regarding flushing with water between individual medications.	nod

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
		00296	B. WING		40/0	2/204.4
					10/0	3/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HOMEST	TEAD REHABILITATIO	ON & LIVING CEN	AVENUE NO 'ER, MN 566			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 930	Continued From pa	ıge 46	2 930			
2 930	compression).  During observation licensed practical naspirin 81 milligram paper medication of milliliters (ml) of lact (gm)/30 ml into a plothen dispensed a h5-325 mg tablet into with the aspirin. Fiir potassium chloride (meq)/15 ml solution then placed the tab sleeve and crushed medication and added 15 mls of medications. LPN-and gloves and ent donned the gloves syringe. LPN-A stochecked the placen as she instilled air indrew 30 mls of water flushed the G-tube. the syringe and instige-tube. LPN-A the syringe with the rem	on 10/01/14, at 11:35 a.m. aurse (LPN)-A dispensed an (mg) chewable tablet into a cup. She then measured 30 ctulose solution 20 gram lastic medication cup. LPN-A ydrocodone-acetaminophen to the paper medication cup nally, LPN-A drew 4 ml of 10% 20 milliequivalents on into a 10 ml syringe. LPN-A olet medications into a plastic distention the medications, placed the ns into a plastic water glass, of warm water to dissolve the A gathered the medications ered R33's room. LPN-A and drew air into a 60 ml apped the tube feeding and ment of the G-tube. LPN-A then er into the 60 cc syringe and Next, she drew lactulose into tilled 1/2 the solution into the maining lactulose and instilled	2 930	Element 3 The policy was reviewed and update appropriate. Licensed nurses were educated about the policy regarding flushing between individual medical when providing medications per General Element 4 The DON/designee will audit medical administration according to policy residents with G-tubes daily x 7 dayweekly x 3 weeks, then monthly x months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow reviewed at QAPI at least quarterly.	e ng ations -tube. cation for all nys, then 2 up and	
		N-A flushed the G-tube with 15 , LPN-A drew the crushed				
	medication and wat	ter solution into the syringe				
	flushed the G-tube LPN-A squirted the syringe into the plan into the 60 ml syring	with 15 ml of water. Next potassium solution from 10 ml stic water glass and drew it ge, and instilled it into the PN-A flushed the G-tube with				
	30 ml water and res discarded her glove	started the feeding. LPN-A es, raised the head of R33's er hands before exiting the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DRESS, CITY, S AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 930	room.  R33's Physician Ore 8/5/14-10/15/14 dire 30 ml of water beform The order did not dimedications.  On 10/01/2014, at 1 pharmacy had told give oral medication had not been instruseparate with flushed on 10/03/2014, at 9 registered nurse (R been instructed by phetween each mediafter a group of meno incompatibilities given concurrently.  On 10/03/2014, at 1 confirmed the physiflush between each  The Enteral Tube M policy date 4/23/14, were not to be mixed was to be administed interaction and clunt to be flushed with a each medication to the medications.  SUGGESTED MET The Director of Nur	der Report dated ected staff to flush G-tube with re and after each medication. Irect the mixing of  I1:51 a.m. LPN-A stated that them they could crush and as together. LPN-A stated she cted to give each medication es between.  I2:32 a.m. the consulting N) indicated the facility had charmacy to either flush ication or flush before and dications as long as there are between the medications  I1:34 a.m. the consulting RN ician orders called for 30 ml medication.  Idedication Administration directed crushed medications at together. Each medication ered separately to avoid apping. The enteral tubing was tolerant to the separately to avoid apping. The enteral tubing was to least 5 ml of water between avoid physical interaction of	2 930			
		ures for medication astrostomy tube (G-tube) and				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 48 of 73

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/0	3/2014
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	1 .0,0	0/2011
HOMEST	TEAD REHABILITATIO	N & I IVING CEN	AVENUE NO	_		
	OLIMANA DV. OTA		VER, MN 566		<u></u>	0.45
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 930	Continued From pa	ge 48	2 930			
	medication adminis Nursing could deleg compliance and rep Committee. TIME PERIOD FOR	n-service for staff regarding tration. The Director of gate nursing staff to monitor port to the Quality Assurance				
	(21) days.					
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			11/12/14
	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 exprevention and com E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the development of the procedures of resid the prevention and F. the development of the procedures which affed disinfectants, antised incontinence products. In methods for the procedures which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of act infection control, such as eptics, gloves, and				

6899

Minneso	Minnesota Department of Health							
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00296	B. WING		10/03/2014			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•			
HOMEST	HOMESTEAD REHABILITATION & LIVING CEN DEER R			DRTHEAST 636				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
21390	Continued From pa	ge 49	21390					
	by: Based on observatireview, the facility facontrol practices for R10, R32, R31, R6 glucose monitoring sugar levels. In additionation control (IC) program program and invest tracking trends and interventions to pre The lack of surveilla 26 of the 26 resider  Findings include:  On 9/29/14, at 5:28 (LPN)-C applied glo R4's finger to check blood glucose monistated they used the all the residents who checks. LPN-C was machine with a san information indicate active ingredient 70 R3 had a physician blood sugar checks R2 had a physician blood sugar checks R10 had a physician blood sugar checks	n's order dated 6/10/13, for		Element 1 The facility reviewed the infection surveillance program and found it completed after May 2014. Surveincluding investigation, trending are analysis of data to determine interto prevent the spread of infections completed for June, July, and Aug 2014. The product used for cleans glucometer was immediately channan EPA approved germicidal clear.  Element 2 The facility completed surveillance September, 2014 and nursing is identifying infections and antibiotic they occur. An EPA approved ger cleanser is used on all glucometer facility.  Element 3 The policy regarding IC surveillance reviewed and the policy regarding cleansing of glucometers was upon appropriate. Licensed nursing standard regarding IC surveillance cleansing of glucometers. An infection of glucometers are ducated regarding surveillance and glucometer cleansing.  Element 4 The Administrator/Designee will as surveillance monthly x 3 months as	had not illance, and eventions is was just, sing the aged to a ser.  If or expected the form of the company of the form of the company of the form of			
	blood sugar checks R31 had a physicia	four times a day. n's order dated 8/21/14, for		quarterly ongoing. Variances will be reviewed at QAPI at least quarterly				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/0	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115 10TH	DDRESS, CITY, S I AVENUE NO VER, MN 566	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	blood sugar checks R4 had a physician blood sugar checks On 9/29/14, at 5:41 told they could not a they would damage stated they were ins wipe towelettes and posted at the nurse On 10/2/14, at 8:49 nursing (DON) state laboratory stated no to clean the BGM m At this time the con stated she would ch instructions for the active ingredients.  At 10:05 a.m. the co surprised that one i would have made th disinfecting product consulting RN state manufacturer's inst reported they did no The consulting RN their disinfecting pro machine back to the blood borne pathog the sani wipe towel and inactive ingredien  At 10:45 a.m. the co	is four times a day. It's order dated 12/6/13, for a daily. It's order dated 12/26/13, for a four times a day.  It's order dated 12/26/13, for a four times a day.  It's order dated 12/26/13, for a four times a day.  It's p.m. LPN-C stated they were use the sani wipe clothes as the BGM machine. LPN-C structed to only use the sani day a sign indicating this was it's station.  It a.m. the interim director of an employee from the control of the day and the sani wipe clothes hachine as it would damage it. It is sulting registered nurse (RN) and the manufacturer's towelettes to determine the consulting RN stated she was individual from the laboratory and the edision to change the state of the BGM machine. The consulting that day for the BGM are sani wipe clothes that do kill the sani wipe clothes and the sani wipe clothes and				
		boratory personnel and stated month since the disinfecting ed.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/0	3/2014
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1070	0/2014
HOMEST	EAD REHABILITATIO	N & I IVING CFN	AVENUE NO	<del>-</del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 51	21390			
	May 2014, was the resident infections vistated the RN who tracking had resign	a.m. the consulting RN stated last time surveillance of was done. The interim DON was doing the IC resident ed and therefore the idents had not been				
	The Surveillance of Health Care associated Infections policy revised 4/12, indicated the infection control officer would perform ongoing total or target house surveillance activities under the direction of the Infection Prevention and Control Committee.					
		sted regarding the disinfecting nachine and none was				
	The director of nurs could review/revise cleaning. The Qual	THOD FOR CORRECTION: sing (DON) and/or designee policy for gulcolmeter lity Assessment and committee could do random mpliance.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	O A.B.C Drug Regimen Review	21530			11/12/14
		en of each resident must be onthly by a pharmacist				

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	
		00296	B. WING		10/0	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
HOMES	TEAD REHABILITATIO	N & LIVING CEN	AVENUE NO VER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21530	currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Mealth Care Finance This standard is in available through the system. It is not sure B. The pharma irregularities to the and the attending properties of the and the attending properties. For purpon means the acreport and the signification of nursing services. C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely after the matter to the attending physician. If the meanth the attending physician does not must be referred for assessment and as by part 4658.0070. The medical director must refer the matter to the assessment and as the system of the medical director must refer the matter than the assessment and as the system of the medical director must refer the matter than the assessment and as the system of the medical director must refer the matter than the system of the medical director must refer the matter than the system of the medical director must refer the matter than the system of the medical director must refer the matter than the system of the medical director must refer the matter than the system of the medical director must refer the matter than the system of the s	y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports n by the time of the next coner, if indicated by the proses of this part, "acted coceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur its recommendation, or does te justification, and the set the resident's quality of life is ested, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality essurance committee required If the attending physician is or, the consulting pharmacist er directly to the quality essurance committee.	21530			

6899

Minnesota Department of Health

Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AIND FLAIN	OI CONNECTION	IDLINIII IOAI ION NUMBE	-13.	A. BUILDING:		COMPI		
				B. WING		4.5.15	0.100.4.1	
		00296		D. WING		10/0	3/2014	
NAME OF I	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	STATE, ZIP CODE			
HOMEST	TEAD REHABILITATIO	N & LIVING CEN. 11	15 10TH A	AVENUE NO	PRTHEAST			
TIOMEO	ILAD KLIIABILITATIO	DI DI	EER RIVE	ER, MN 566	336			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21530	Based on observation review, the consultation and report on the end of the en	on, interview and document pharmacist failed to fficacy of pain medication, R11) who had chronic sultant pharmacist failed to a dosage reduction and the use of an antidepressy the lack of monitoring epressant used for insor (R10, R1) reviewed for	identify ons for pain. to d/or ssant, for mnia  ated on,	21530	Element 1 The consulting Pharmacist has revithe medication irregularities relate PRN pain medications for resident R11, who had chronic pain. Chanchave been made as recommender consulting pharmacist reviewed R R1 is routing medication irregularismade recommendations as approximate recommendations as approximate resident charts for PRN and round resident charts for PRN and round appropriate recommendations.  Element 3 The policy and contract regarding consulting pharmacy services and medication review was reviewed were recommendation review was reviewed were resident.	d to as R6, ges d. The 14 and atties and priate.  viewed utine		
	also indicated R6 s which prevented he activities. During the reported her pain to worst) pain scale.  R6's care plan date alteration in comforting the hands second and muscle spastic palsy. The plan directs and responding plan did not direct spotential leg pain at non-pharmacologic R6's pain.	estive heart failure. The luffered from frequent participating in date assessment period, For be at a 6 on a 0-10 (10 dd 6/4/14, identified an a trelated to numbness/tidary to carpal tunnel syrity secondary to cerebratected staff to anticipate in a timely manner. The staff on how to minimize and it did not include al interventions to minimizer Report dated 9/5/14,	ain aily R6 had 0 is  Ingling Indrome al her he care		consulting pharmacist. The consupharmacist has access to the EMF efficiency of pharmacy review.  Element 4 The DON/Designee will audit the consulting pharmacist report montongoing. Variances will be reported Administrator for immediate follow reviewed at QAPI at least quarterly	hly ed to the up and		

(X3) DATE SURVEY COMPLETED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_\_\_\_\_\_\_

00296 B. WING \_\_\_\_\_\_ 10/03/2014

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	NAME OF F			STATE, ZIP CODE	
PREFIX TAG    CADITION   CAST   CAST	HOMEST	FAD REHABII ITATION & LIVING CEN			
included Baclofen (muscle relaxer) 10 mg three times a day, Gabapentin (medication used to treat nerve pain) 300 milligrams (mg) three times a day, Tylenol extra strength 500 mg one tablet every four hours as needed (PRN) for pain, and Fentanyl (narcotic pain patch) 25 micrograms (mcg)/ hour to be changed every three days.  On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh."  On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head.  At 9:10 a.m. nursing assistant (NA)-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication.  On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
times a day, Gabapentin (medication used to treat nerve pain) 300 milligrams (mg) three times a day, Tylenol extra strength 500 mg one tablet every four hours as needed (PRN) for pain, and Fentanyl (narcotic pain patch) 25 micrograms (mcg)/ hour to be changed every three days.  On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh."  On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head.  At 9:10 a.m. nursing assistant (NA)-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication.  On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg work her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is	21530	Continued From page 54	21530		
cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head.  At 9:10 a.m. nursing assistant (NA)-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication.  On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is		times a day, Gabapentin (medication used to treat nerve pain) 300 milligrams (mg) three times a day, Tylenol extra strength 500 mg one tablet every four hours as needed (PRN) for pain, and Fentanyl (narcotic pain patch) 25 micrograms (mcg)/ hour to be changed every three days.  On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh."			
cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication.  On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is		cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh			
experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is		cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting			
		experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN. 115 10TH	DDRESS, CITY, S AVENUE NO VER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 55	21530			
		ronic medication rd (EMAR) revealed the n about excessive use of as				
	7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol.					
	7/1/14 - 7/31/14, R6 PRN Tylenol.	6 had received 90 doses of				
	8/1/14 - 8/31/13, R6 Tylenol 500 mg.	6 received 81 doses of PRN				
	9/1//14 - 9/30/14, R Tylenol 500 mg.	6 received 98 doses of PRN				
	10/1/14- 10/2/14, R PRN Tylenol 500 m	6 had received 6 doses of g.				
	(LPN)-B stated R6 "all of the time." Sh medications and wi the four hours to pa next pill. LPN-B sta	0 a.m. licensed practical nurse reported complaints of pain he stated R6 will request pain II watch the clock waiting for less before she can ask for the lated R6 was uncomfortable, "I something to give her relief."				
	with the interim directonsultant registers DON stated she was daily. The two RNs and were unable to staff had completed assessment of R6's determine if the Fermine consultant to the staff had completed assessment of R6's determine if the Fermine consultant registers.	s pain and were unable to ntanyl which had been added iffective medication for				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER TEAD REHABILITATIO	ON & LIVING CEN. 115 10	TADDRESS, CITY, S TH AVENUE NO RIVER, MN 566	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	On 10/2/14, at 11:2 confirmed R6 expe been comprehensive to determine the existe was aware R6 for the treatment of was utilizing over 7.  Review of the montemedication regimenhad been complete identified by the pharmacist stated sone month ago. She consult, she did not medical records or had not reviewed R she did not have ach and the stated if she were identified by the attention of the attention of the attention of the attention of the cartilage), chronically significant chindicated R11 had stated in the cartilage of the cart	0 a.m. the consultant RN rienced pain daily and had not rely reassessed by the nurse stent of the pain. She stated was utilizing PRN medication pain but was not aware she of PRN medications per more the consultant pharmacist in reviews indicated the review distributed without any type of concernancist.  In p.m. the consultant she started visiting the facilities the started at the time of the thave access to the electron EMARs. She confirmed she coess at the time of the review ould have noted that a rigg over 80 PRN doses of pain nonth, she would have point ding physician.  In edication reviews was elewas provided.	ns en th. ws ens  y nic en the			

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 57 of 73

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00296	B. WING		10/0	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOMEST	TEAD REHABILITATIO	ON & LIVING CEN	AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	locomotion on and personal hygiene a staff for bed mobilit and corridor and to indicated R11 receipain medication an for pain. The MDS her pain as modera interfere with daily sleep at night. The received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the therapy (OT) service of motion (ROM) received physical the received physical the received physical scale of pain medication. The Nursing Home R11 was seen regated to pain, delirium, he physician's impressive tebral compression the physician's pla medications until R (identified upon physical was hospitalized 8/4/14, for pneumon the facility complete the staff of the physical service was a staff of the physician's pla medications until R (identified upon physical service).	off the unit, dressing and nd limited assistance of one ty, transfer, ambulating in room illet use. The MDS also ived scheduled and as needed d non-medication interventions also indicated R11 reported ate and frequent but it did not activities or make it difficult to a MDS further indicated R11 herapy (PT) and occupational ces and received active range estorative nursing services.  Ited 7/17/14, identified R11 had at related to pain secondary to sion fractures of her back and d verbally state pain was 2-3 f 0-10 after administration of the care plan directed staff to cions as ordered for pain and to eness of pain medications and ts.  Note dated 7/29/14, indicated arding family concerns related earing and intake issues. The sion included pain issues with sion fractures and arthritis. In was to not change the shortness of breath sysician examination) was				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00296		B. WING		10/0	03/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HOMEST	EAD REHABILITATIO	ON & LIVING CEN		AVENUE NO /ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	during the assessment of the Physician Order 9/3/14-10/3/14, included adhesive patch (a lemilligrams (mg)/pat topically to mid-back hours for chronic pareliever for moderathree times a day (s (hydrocodone-acetatwice a day PRN for 500 mg 1 tab every)  R11's Medication Are 8/8/14-10/3/14 reversed early adays.  -Norco 5-325 mg dose) was given ear 8/25, 9/12, 9/22, 9/210/2, and 10/3 and (11 doses).  R11's PRN Medicate 8/8/14-10/3/14 reversed early adays.  -Norco 5-325 mg doses were given of pain in knees or acetaminophen as needed was given and given three timpain in knees or leg On 10/2/14, at 9:04	R11 had complained nent period.  er Report dated uded orders for Lido ocal anesthetic) 5% (ch) apply 1 new pate k daily on 12 hours a ain, Norco (narcotic te to severe pain) 5-scheduled dose), No aminophen) 5-325 m r pain, and acetamin 6 hours PRN for pate dministration History ealed: sive patch 5% was at R11's request 30 of three times a day (orly for the morning dots), 9/26, 9/29, 9/30, for the afternoon dost tions Administration I ealed: g 1 tab twice a day Pon 29 of 57 days for orders.  1500 mg 1 tab every en once on 8/8, 8/30 es on 10/2 for complist.	derm (700 ch and off 12 pain 325 mg rco g 1 tab ophen in. dated of 57 scheduled ose on 10/1, se on 9/9 History RN, 32 complaints 6 hours and 9/3 laints of	21530			
	seated in her room	seated in a recliner. n having a lot of prol	R11				

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 59 of 73

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		
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DRESS, CITY, S AVENUE NO VER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	her right knee and iknee and began to observed to be swo given pain pills for the lasted a little while. She stated that on packs, as well, and stated the pain kee that the previous nifinally got a pain pill medication lasted for knee began hurting asks for a pain pill a identified her pain a continuous of the limited her activities her from joining in. R11 stated her knee a 7 out of 10 on a 1 her knee hurt all the sat "absolutely still." walking made her knee pain. She pain medication, it would also her knee pain. She pain medication, it would also her knee pain. She pain medication regimer had been complete	raised her pant leg above her rub it. The knee was ollen. R11 stated she was he knee pain and that they but they don't last forever."  10/1/14, she was given cold that helped for a little bit. R11 ps her up at night at times and ght she was "up a lot" until she I. R11 stated the pain or about 4 hours before her again. R11 also stated she a couple of times a day and at that time at an 8 out of 10.  3 a.m. R11 was observed in a recliner with a wheeled er chair. R11 stated the pain so during the day and prevented She stated, "I just can't do it." the currently still ached and was to 10 pain scale. R11 stated the time but it was alright if she "R11 further indicated"	21530			

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) F

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED
7. Bolesino.	
<b>00296</b> B. WING	10/03/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO	DE
HOMESTEAD REHABILITATION & LIVING CEN DEER RIVER, MN 56636	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
On 10/2/14, at 3:45 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She confirmed she had not reviewed R11's pain medication usage as she did not have access at the time of the review.  A policy related to medication reviews was requested and none was provided.  R10's Physician Order Report dated 9/3/14, directed Paxil (an antidepressant medication) 10 mg daily for the treatment of depression. The medication was started on 7/3/2013. The clinical record lacked documentation of an attempted dose reduction since start date of 7/13. In addition, the record lacked documentation why a reduction would be contraindicated for R10.  R10's quarterly MDS dated 9/5/14, and the annual MDS dated 7/1014, identified R10 as being alert and oriented with no mood or behavior concerns. The assessment indicated R10 received antidepressant medications daily.  The Psychotropic Medication Use Care Area Assessment dated 7/10/14, indicated R10 participated in activities and did not not show signs of depression.  The care plan dated 7/15/14, identified R10 as receiving antidepressant medication for the treatment of major depression and sleeplessness. The care plan directed the staff to encourage the resident to stay up after meals and to participate in activities in the facility.	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00296	B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN. 115 10TH	DRESS, CITY, S AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	On 10/1/14, at 12:2 occasional sleep what stated R10 does not depression.  The Consultant Phacompleted on 12/10 Medicare/Medicaid two gradual dose refirst year for all psysmedication to deter the order." "Consider any reduction would psychiatric distress benefits for this dose "He is on the lowes his depression is go	ge 61 0 p.m. RN-A stated R10 will hen he is depressed. She at show any other symptoms of armacist Medication Review 0/13, read: "CMS (Center for services) regulations required eductions or assessment the chopharmacological mine the continued need for ler a reduction or, if you feel d put resident in undue, please list the risk and se." The physician responded, t dose and tolerated well and bod continue med." The note y reduction would be	21530			
	the consultant phar antidepressant med attention of the phy the medication has time. RN-B stated F does not show any depression.					
	pharmacist stated sone month ago. She consult, she did not medical records or noticed R10 was reshe should make a until she could reviet to know the residents confirmed residents.	p.m. the consultant she started visiting the facility he stated at the time of the thave access to the electronic EMARs. She stated she had ceiving Paxil but did not feel my type of recommendations ew the clinical record and get at a bit more. The pharmacist is receiving antidepressants attempted dose reductions				

6899

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00296		B. WING		10/	03/2014
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	ORESS CITY S	STATE, ZIP CODE	1	00/2011
				AVENUE NO			
HOMES	TEAD REHABILITATIO	ON & LIVING CEN	DEER RIV	ER, MN 566	36		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ge 62		21530			
	during the first year						
	indicated diagnoses dysthmic disorder (a thoracic spondylosis of the joints betwee vertebrae) and inso orders printed 10/2/antidepressant) 50  R1's quarterly MDS was cognitively inta R1 had poor appetit bad about himself 2 antidepressant med R1's care plan date received nortriptylingoal for R1 to received	dated 7/10/14, indicated. The MDS also indicate or overeating 2-6 days, and received dication daily and 7/16/14, indicated Refor sleep and identificate the lowest dose of	e pain, ession), arthritis inal vsician's ne (an ted R1 icated ays, felt				
	insomnia. The care	ate signs and symptor e plan directed staff to toms of depression, a	monitor				
	Regimen Review R nortriptyline was sta	armacist's Medication eport dated 7/25/12, ic arted October 2011 an nic pain and neuropatl a and depression.	d was				
	medication reviews been completed wit	thly consultant pharma indicated the reviews thout any concerns reg entified by the pharma	had garding				
		d indicated the most reseasement was dated	ecent				

6899

PRINTED: 11/12/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING 00296 10/03/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST HOMESTEAD REHABILITATION & LIVING CEN DEER RIVER, MN 56636 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21530 Continued From page 63 21530 On 10/01/2014, at 1:10 p.m. RN-A stated the facility's side effect monitoring process had just been reorganized and they were planning to start on 10/1/14. RN-A confirmed no sleep monitoring had been done for R1 since December 2013. RN-A stated the facility had lost some staff last year and this had been missed. On 10/02/2014, at 8:38 a.m. interim DON confirmed sleep monitoring had not been completed since December 2013, and should have been, as directed by the care plan. DON confirmed she would have expected the pharmacist to have identified the lack of sleep monitoring for the medication. On 10/2/14, at 3:49 p.m. the consultant pharmacist stated she only made one visit to the facility and had not had a chance to get to know the residents and their history. She stated the physician may have changed the indication for R1's nortriptyline use to address his neurogenic pain rather than for sleep and then may have suspended sleep monitoring. A policy regarding sleep monitoring was requested but none was provided.

6899

Minnesota Department of Health STATE FORM

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee and the consulting pharmacist could establish a system to

medications and assure adequate indications for

monitor residents recieving antipsychotic

use are identified. The quality assurance committee could review the process to ensure

continued compliance.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY LETED	
		00296	B. WING		10/0	3/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HOMEST	TEAD REHABILITATIO	N & I IVING CFN	AVENUE NO 'ER, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 64	21530			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1315 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			11/12/14
	monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is a the medical director is a the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician does not the attending physician does not the order and if the change the order, the attending physician does not the qualit (QAA) committee rethe attending physician does not the attending physician does not the order and if the change the order, the attending physician does not the qualit (QAA) committee rethe attending physician does not the order and if the change the order and the ord	g. A nursing home must ent's drug regimen for isage, based on the nursing I procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist of the pharmacist must refer the all director for review if the not the attending physician. If the determines that the attending have adequate justification for attending physician does not not matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter				
	by: Based on observati review, the facility for reduction for the us failed to monitor eff used for insomnia for	ent is not met as evidenced on, interview and document ailed to attempt a dosage e of an antidepressant, and icacy of an antidepressant or continued need, for 2 of 5 reviewed for unnecessary		Element 1 Residents R14 s and R1 s mediwere reviewed for clinical indication gradual dose reductions (GDR) with made when the clinical indications the benefit outweighs the risk to diand the rationale is documented in	ons, ere s reveal ecrease	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00296	B. WING		10/0	3/2014
NAME OF PROVIDE	ER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
HOMESTEAD R	REHABILITATIO	N & LIVING CEN	AVENUE NO ER, MN 560			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540 Conti	nued From pa	ge 65	21540			
Findi	ngs include:			patient chart.		
R10's direct millig depre 7/3/2 docur since lacke control R10's 9/5/1 identify mood indica media. The F Asse partic signs. The creceive treater sleep encount to particular particular sleep encount to particular particular sleep encount to particular slee	s Physician Or red Paxil (an arams (mg) dai rams (mg) dai rams (mg) dai rams (mg) the residual rams (mg) the control of a start date of 7 d documentate aindicated for a quarterly Min 4, and the annified R10 as before a feed R10 receivations daily.  Psychotropic Newsment dated aindicated in activity of depression are plan dated aindicated in activity of depression activity of depression are plan dated aindicated in activity of depression activity of depre	nimum Data Set (MDS) dated and MDS dated 7/1014, eing alert and oriented with no concerns. The assessment eived antidepressant  Medication Use Care Area 7/10/14, indicated R10 rities and did not not show		Element 2 All residents who take psychotrop medications were assessed for infor use, appropriateness of gradus reduction and documented rational Element 3 The policy was reviewed and update appropriate. New admission medit will be reviewed for appropriate infor use. The consulting pharmacia audit all resident is medication remonthly. SW/RN will monitor all psychotropic medications for gradustionale at least quarterly. SW, consulting pharmacist and RNs will educated regarding the protocol for gradual dose reduction.  Element 4 The consulting pharmacist will autoresident is medication regime mode SW/RN will review each resident medication regimen at least quarter the DON/designee will monitor psychotropic medications for GDF documentation of rationale explain benefit vising risk weekly in a weeks, the monthly in a month of the protocol for the pr	dications al dose ale.  ated as cations dications st will gimens lual dose fit vs risk ere or dit each onthly.  R or ning the then r ted to the vup and	

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 66 of 73

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00296	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DRESS, CITY, S AVENUE NO /ER, MN 566			
(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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21540	not observed to discontinuous of the consultant Phace of the order." "Consider the order." "Consider any reduction would psychiatric distress benefits for this dose "He is on the lowes his depression is godid not address why contraindicated.  On 10/1/14, at 1:30 the consultant phare attention of the phythe medication has time. RN-B stated F does not show any depression.  R1's Resident Admindicated diagnoses dysthmic disorder (thoracic spondylosi of the joints between vertebrae) and insorder.	play symptoms of depression.  O p.m. registered nurse will occasional sleep when he stated R10 does not show any depression.  Armacist Medication Review 0/13, read: "CMS (Center for services) regulations required eductions or assessment the chopharmacological mine the continued need for der a reduction or, if you feel deput resident in undue, please list the risk and dee." The physician responded, at dose and tolerated well and dood continue med." The note of reduction would be  p.m. RN-B stated confirmed macist brought the concern of dication reduction to the sician in 12/13, but confirmed anot been addressed since that R10 occasionally naps but other symptoms of  dission Record dated 10/2/14, as that included chronic pain, a chronic type of depression), as (degenerative osteoarthritis in the center of the spinal mina. The current physician's 1/14, directed nortriptyline (an	21540			

Minnesota Department of Health

STATE FORM 5J6W11 If continuation sheet 67 of 73

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED		
		00296		B. WING		10/	03/2014
	PROVIDER OR SUPPLIER	ON & LIVING CEN	115 10TH	DRESS, CITY, S AVENUE NO ER, MN 566	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ( MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	Continued From pa	ge 67		21540			
	was cognitively inta R1 had poor appeti	dated 7/10/14, indicate. The MDS also in te or overeating 2-6 2-6 days, and received dication daily	dicated days, felt				
	1/10/14, indicated F aware of reasons for willingly to psych visionew symptoms. The potential for unwant	Medication Use CAA R1 was alert and oried or medication use. His sits and was able to see CAA also indicated ted side effects from a pressant medication	ented, and le went self report d a the use				
	received nortriptylin goal for R1 to recei medication to allevi insomnia. The care	ed 7/16/14, indicated the for sleep and identity to the lowest dose of ate signs and symptote plan directed staff the toms of depression,	tified a f oms of o monitor				
	Regimen Review R nortriptyline was sta	armacist's Medication eport dated 7/25/12, arted October 2011 a nic pain and neuropa a and depression.	identified and was				
		d indicated the most ssessment was dated					
	participating in a be lounge area. R1 wa	2:14 p.m. R1 was obe ean bag toss activity as as observed to be en the activity. His affect	in the ngaged				
	On 10/01/2014, at	1:10 p.m. RN-A state	d the				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: \_\_\_\_\_

(X3) DATE SURVEY COMPLETED

00296

B. WING \_

10/03/2014

HOMESTEAD REHABILITATION & LIVING CEN:  115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (TO SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (TO SUMMARY STATEMENT OF DEFICIENCIES)	
(X1)15	
	(X5) OMPLETE DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE	OMPLETE

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E SURVEY PLETED	
		00296	B. WING	10/	03/2014
	PROVIDER OR SUPPLIER	N & LIVING CEN 115 10TH	DRESS, CITY, AVENUE NO YER, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From pa	ige 69	21695		
21695	Subp. 4. Houseke	5 Subp. 4 Plant eration, & Maintenance eping. A nursing home must ing and maintenance services	21695		11/12/14
	necessary to mainta comfortable interior	ain a clean, orderly, and including walls, floors, including walls, floors, including, equipment, lighting,			
	by: Based on observation review, the facility for rooms and common repair for 8 of 8 res	ent is not met as evidenced ion, interview, and document ailed to maintain resident n areas clean and in good sident rooms (#121, 126, 132, and 105) and throughout the ility corridors.		Element 1 Resident rooms (121, 126, 132, 101, 102, 103, 104, 105), bathrooms, and common areas as identified during the survey have been maintained, cleansed and painted.	
	Findings include:			Element 2 An audit of resident rooms, bathrooms, and common areas was performed for	
	completed with the -The south wall of t marks approximate -The long wall of th and had a chair rail down from the chai scuff areas on the v -The East wall of th with a chair railing, from the chair railin areas on the wallThe West wall of tl 33 inches with vario -The back North dir foot, and the East v	5 a.m. a tour of the facility was maintenance director (MD). he dining room had black scuffely 4 feet by a 1 foot area. e dining room was 22 feet longing. Approximately 4 inches r railing were numerous black wall. The dining room was 5 feet long approximately 4 inches down g were numerous black scuff he dining room was 7 feet by bus black scuff marks. The dining room wall was 3 feet by 1 wall was 14 inches by 10 have numerous black scuff		identification of other areas in need of maintenance, cleansing or painting.  Element 3 A mechanism is in place for maintenance notification of resident rooms, bathrooms, and common areas in need of maintenance, cleansing or painting. All staff has been educated on identify, reporting, and obligation to provide clean and sanitary conditions. There is schedule for maintenance to observe resident rooms, bathrooms, and common areas in need of maintenance, cleansing, paint.  Element 4 The Administrator/Designee will audit	
	marks.	lave numerous diack scuff		maintenance observation schedule and	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S COMPL		
		00296	B. WING		10/0	3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HOMES	TEAD REHABILITATIO	N & LIVING CEN	AVENUE NO ER, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 70	21695			
	of plastic. The MD s could be removed be a magic eraser. The	dining room walls were made stated the black scuff marks by the housekeeping staff with a MD stated they had also ing paint for the plastic in the		repair work weekly x 4 weeks, the monthly x 2 months and quarterly Variances will be reviewed at QAF least quarterly.	ongoing.	
	was 8 feet by 10 ind scuff marks.  -The West wall outs feet by 15 inches w marks.  -The West corridor feet by 12 inches w marks.  -The East wall outs by 12 inches with no marks.  -The East wall outs by 12 inches with no marks.  -The walls by the resinches by 3 feet, and black scuff marks.  -The West wall of the inches. The South with the East wall was 7 numerous black scull room 121 there wooden door to the lin room 126 there missing from the wall room 132 there wooden door to the lin room 101 the wall addition, there was over the chipped wooden wall room was sover the chipped was resulted.	were several gouges in the room. was sheetrock and paint alls. were several gouges in the				

6899

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	
		00296	B. WING		10/0	3/2014
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21695	In room 102 there bed. The South wal numerous black sci-ln room 103 there wooden door to the In room 104 the Winches and the Sou with numerous black In room 105 the bas 45 inches by 7 inch metal. The East wa with black scuff ma  The entire East han numerous black scuff marks of walls.  The North hallway black scuff marks of walls.  The MD stated the wheelchairs and metal cleaning and the wall	was paint missing above the I was 80 inches by 3 feet with uff marks were several gouges in the room. Test wall was 3 feet by 12 th wall was 4 feet by 1 foot lek scuff marks. Athroom register had an area es scraped down to the bare II was 41 inches by 13 inches rks.  Ilway 100 feet long had uff marks on the lower level of 74 feet long had numerous on the lower level of the plastic black scuff marks were from echanical lifts hitting the walls. housekeeping staff did the ne maintenance staff would do	21695			

6899

PRINTED: 11/12/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING 00296 10/03/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 10TH AVENUE NORTHEAST HOMESTEAD REHABILITATION & LIVING CEN DEER RIVER, MN 56636 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21695 Continued From page 72 21695 At 9:30 a.m. the NSM stated they do extra cleaning during an eight week period in the spring. The NSM stated there was no documentation the cleaning was done. The routine housekeeping policy dated 1/91, indicated the facility would be maintained in a clean, sanitary, and orderly condition. During the extra cleaning which covered an eight week period all the walls in hallways, resident rooms and bathrooms would be washed. SUGGESTED METHOD OF CORRECTION: The director of facility operations or his designee could develop a system to ensure the environment was clean, comfortable and checked on a routine basis. The director of facility operations or his designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The director of facility operations or his designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty one (21) days.