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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 6ZS1
Facility ID: 00474

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245402**

2. STATE VENDOR OR MEDICAID NO. (L2) **938342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

4. TYPE OF ACTION: 7 (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/03/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE
Gail Anderson, Unit Supervisor
Date : 05/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Kamala Fiske-Downing, Enforcement Specialist
Date: 05/11/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245402
May 9, 2018

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

Dear Ms. Krueger:

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 April 24, 2018 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2018

Ms. Mary Krueger, Administrator A
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

RE: Project Number S5402028

Dear Ms. Krueger:

On April 3, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 15, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 3, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 24, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 15, 2018, effective April 24, 2018 and therefore remedies outlined in our letter to you dated April 3, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ZS1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00474

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2. STATE VENDOR OR MEDICAID NO. (L2) **938342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENWOOD VILLAGE CARE CENTER**
(L4) **719 SOUTHEAST 2ND STREET**
(L5) **GLENWOOD, MN** (L6) **56334**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/15/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

12. Total Facility Beds **64** (L18)

13. Total Certified Beds **64** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE: Susan Bachleitner, HFE NE II — Date: 04/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Debby Baker, Enforcement Specialist — Date: 05/10/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 3, 2018

Ms. Mary Krueger, Administrator
Glenwood Village Care Center
719 Southeast 2nd Street
Glenwood, MN 56334

RE: Project Number S5402028

Dear Ms. Krueger:

On March 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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:

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

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

Remedies - 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;

Potential Consequences - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 24, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 15, 2018 (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 September 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING ______ B. WING ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/12/18 to 3/15/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 12th through March 15th, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend	F 565		4/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 04/12/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING ______ B. WING ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 1 resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to take prompt action to resolve grievances from resident council for 12 of 12 residents (R54, R3, R16, R29, R35, R11, R33, R8, R27, R22, R34, R40) with concerns of cold food and snacks not being served. Findings include: On 3/13/18 at 1:48 p.m. a resident council meeting was held and the following residents	F 565	The Dietary Director held a dietary staff meeting on 4/10/18 to educated staff on what proper food temperatures are and also proper ways of taking food temperatures. We also discussed that tray audits will be performed to ensure proper temperatures of food at time of service on households. These audits will be done a minimum of 2x monthly at varying meal service. Additional test trays will be completed as needed based on resident	

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F 565	Continued From page 2 attended the meeting R54, R3, R16, R29, R35, R11, R33, R8, R27, R22, R34, R40. During the meeting the following concerns were voiced: -residents voiced concerns that a snack cart was not available and staff only provided snacks at times if residents asked for them. The residents indicated the only time they were offered snacks was for the Bingo activity. -residents voiced concerns about food being cold, indicated they would send the cold food back to the kitchen, would be reheated and indicated the food was not very appetizing then. The residents indicated the food was barely warm at times, but most of the time the food was cold. -residents voiced concerns they did not know what a grievance was and was not sure how to file a grievance. Review of Resident Council Minutes and Food Council Minutes from 8/17 to 2/18 revealed the following: -8/15/17, residents voiced concerns vegetables were cold. -9/17, no food council meeting. -10/24/17, residents voiced concerns about carrots being cold, staff not going around offering bedtime snack and food not hot enough on the evening meal. -11/22/17, residents voiced concerns about bedtime snacks not being offered at all and food not hot enough on the evening meal.	F 565	complaints identified from resident comments or Food Council. Audit data and new complaints/concerns will be implemented into QAPI and QAA processes. Handouts were given at this meeting related to our test tray policy and proper food temperatures. This repeat session will be held again on 4/17/18 for those that did not attend the previous meeting. Individual meeting will be set up for those that did not attend either one of these meeting. Results will be monitored at the monthly QAPI meeting and Quarterly QA meeting. Person Responsible: Dietary Director Snack cart will be provided every evening at HS. The snack cart has been assigned to a specific staff person on each station. The staff person will offer a snack to each resident on the station. The staff person will chart in POC if resident received snack or refused snack. Dietary staff will prepare the snack cart and distribute the carts out to the stations. Snack cart will be started 4/16/18. Note passed out on each station in regards to who is responsible for passing the snacks, charting on the snacks. Snack cart will also be addressed in nurses meeting on 4/18/18 and NAR meeting 4/19/18. Snack cart will be addressed at resident group on 4/24/18. Nourishment policy was reviewed and updated. Audits will be conducted by auditing POC charting and randomly asking residents if they received a HS snack weekly x 3 weeks. Results will be monitored at the monthly QAPI	

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F 565	Continued From page 3 -12/27/17, residents voiced concerns about food not hot enough on the evening meal. -1/31/18, residents voiced concerns about food not hot enough and wanted the food served hotter. -2/28/18, residents voiced concerns about cold food on Blue Horizon wing and especially the soups. Food council notes indicated the food was not hot enough on all households during the evening meals. On 3/13/18, at 3:34 p.m., a request to review the facility's grievance forms since the last survey was done with the licensed social worker (LSW). She stated at that time the facility had not received a resident grievance since 2016. 3/13/18 at 2:24 p.m. activity director (AD) confirmed she usually held the resident council meetings and the dietary manager (DM) held the food council meeting on the same day. The AD indicated she usually left the meeting once the food council meeting started with the DM and indicated she had held the last food council meeting for the DM due to her not being able to attend. The AD confirmed she had received complaints about the food being cold at the last food council meeting, filled out a action form and forwarded the form to the DM. The AD indicated she was not aware the residents had complaints about cold food and snacks not being offered in the evenings until she held the food council meeting for the DM. The AD indicated she was unaware the resident did not know what a grievance was and did not know how to file a	F 565	meeting and Quarterly QA meeting. Person Responsible: Nursing Director The resident grievance policy and procedure was reviewed and revised on 4.11.18. Reviewed policy and grievance form with nursing staff at NAR meeting on 4/18/18 and 4/19/18. New policy and form reviewed with department heads and were instructed to disseminate to his/her staff. This will be reviewed at the next resident council meeting scheduled for 4.24.18 and the next family council meeting. Results will be monitored at the monthly QAPI meeting and Quarterly QA meeting. Person Responsible: Administrator Corrective Action Completed by 4.24.18	

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grievance and did not offer when grievances were last reviewed at the council meetings.

Review of Council Action Forms from 8/17 to 2/18 revealed the following:

-3/5/18, a Council Action Form was filled out for cold food on Blue Horizon and clothing protectors. The form was given to the dietary manager (DM) and indicated the form should be returned to the council by 3/26/18. The form was blank and had not been filled out for recommendations/resolution and implementation. The Council Action Forms lacked documentation regarding the above concerns and had not been addressed in the Council Action Forms for the last 7 months.

No further action forms were available for review.

On 3/13/17 at 2:41 p.m. DM confirmed she was aware of the resident complaints of cold food and snacks not being offered to the residents at bedtime. The DM indicated she had educated a few of her staff members about these issues in the past, and confirmed she had been aware of the complaints since before Christmas time. The DM indicated the nursing staff was responsible for offering the evening snacks to all the residents and indicated snacks were available in the households for the residents. The DM indicated she felt residents were aware snacks were available and would usually ask if they wanted a snack. The DM indicated her expectation of staff were to serve quality hot food, restaurant style service and nursing staff should be offering/asking the residents if they want a bedtime snack. The DM indicated she aware of the food complaints and was aware of the

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continued food concerns and had not initiated any resolution to the action form dated 3/26/18..

On 3/13/18 at 3:04 p.m. nursing assistant (NA)-C indicated she works on all the units in the facility and indicated that she had some residents that would request snacks, otherwise the other residents are not offered snacks routinely. NA-C indicated she was not sure if staff were supposed to offer all the residents a snack and stated "I was never been told to." NA-C indicated she had heard residents complain about the food being cold at least once a week and indicated she felt the complaint of cold food was pretty wide spread throughout the facility residents. NA-C indicated she would try to offer them something else or would try to warm up their food for them. NA-C indicated she was aware several residents were frustrated with the cold food and indicated she felt they had a have a right to be. NA-C indicated she had not reported the complaints about cold food to anyone in the facility.

On 3/13/18 at 3:17 p.m. director of nursing (DON) confirmed the facility policy and indicated a grievance would be filed with a verbal complaint. The DON indicated the facility used an action plan to address the complaint and would ask the resident/family if they want to fill out a grievance if the problem did not get resolved. The DON indicated she was not aware of residents complaining about cold food or snacks not being offered in the evenings. The DON indicated the residents had access to the snacks in the households and indicated staff should be routinely asking the residents if they want a snack. The DON indicated her expectation of staff would be for staff to follow up on the

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F 565	Continued From page 6 complaints, coming up with a resolution and auditing the concerns with the food being cold and snacks not being served. On 3/13/18 at 3:34 p.m. (LSW) confirmed the facility would file a formal grievance if a family member/resident asked to file one and then they would address it. The LSW indicated she would direct them to the department in which the concerns was involved and if not satisfied, then the issue would be sent up the chain of command. The LSW indicated her only involvement in the grievance process was when she reviewed the information during the admission process. The LSW confirmed they have not had any formal grievances since 2016 and she had not filled out a grievance form in the last year. The LSW indicated she was not sure if they talk about the grievance process at resident council and confirmed she had not talked about in resident council. Review of facility policy titled, Grievance Procedure revised on 8/17, indicated if the resident or family member is unable to resolve the problem at the department level, then they will contact the chief executive officer to discuss issues. All concerns would be addressed as soon as possible, not to exceed 10 working days.	F 565		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances	F 676		4/19/18

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F 676	Continued From page 7 of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with grooming for 1 of 1 resident (R25) observed to have grooming needs during survey. Findings include:	F 676	It is the intent of Glenwood Village Care Center to provide the necessary care and services to ensure that a resident s abilities in activities of daily living do not diminish unless the circumstances of the individual s clinical condition demonstrate that such diminution was	

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F 676	Continued From page 8 R25's Medication Report, signed 1/17/18, listed R25's diagnoses which included Alzheimer's disease, amnesia, and weakness. R25's admission Minimum Data Set (MDS) dated 10/17/17, identified R25 had severe cognitive impairment, required supervision with all transfers and mobility, and extensive assistance with dressing, toileting and personal hygiene. R25's Care Area Assessment (CAA) dated 10/21/17, identified R25 had dementia with confusion, wandered and had limited safety awareness. The CAA identified R25 was pleasant with a quiet disposition and not harsh to others. Further, the CAA identified R25 had been noted to need assist with personal hygiene issues, did not appear to care about hair, clothes and cleanliness and required assistance with dressing, toileting, and personal hygiene. R25's computerized care plan revised 2/18/18, included R25 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions and a self care deficit: dressing, bathing and personal hygiene, with a goal for R25 to be clean and well groomed through the review. R25's care plan listed various interventions which included staff to provide set-up assistance cueing and supervision with extensive assist of one as needed. On 3/12/18, at 1:39 p.m. R25 was dressed in street clothes,seated in stationary chair at a table, coloring in the common area of the unit. R25's grey/brown hair was uncombed, with her hair flat to the back of her head. R25's scalp was visible at the back of her scalp, through an uneven part,	F 676	unavoidable. R25 care plan was reviewed and remains appropriate for grooming. Staff is waiting on family to give permission for resident to have her hair cut. Staff assist resident with combing her hair throughout the day when staff notice her hair to be uncombed. Staff assist all residents that are dependent on staff for combing hair throughout day as needed. Will review all resident care plans for grooming. Resident dignity policy reviewed and remains appropriate. Staff will be re-educated on combing all residents hair at nurses meeting on 4/18/18 and NAR meeting 4/19/18. Random audits will be conducted weekly x 3 weeks to assure resident s hair is combed. Audits will also be conducted on other residents throughout the facility to assure hair is combed. Results will be monitored at the Quarterly QA meeting. Responsible Person: Director of Nursing. Corrective Action Completed by: 4.19.18	

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and her hair was flat and pushed forward around her ears and side of head.

On 3/13/18, at 8:32 a.m. R25 was seated in the small dining area with two other residents, near the birds and television (TV). R25 independently fed herself breakfast food items. R25's grey/brown hair was uncombed, with her hair flat to the back of her head. R25's scalp was visible at the back of her scalp, through an uneven part, and her hair was flat and pushed forward around her ears and side of head.

On 3/13/18, at 1:34 p.m. R25 was seated in the dining area near the TV with five other residents seated in various chairs in the room. R25's hair remained uncombed, with her hair flat to the back of her head, scalp visible at the back of her scalp, through an uneven part, and her hair flat and pushed forward around her ears and side of head.

On 3/14/18, at 7:56 a.m. R25 was seated on a stationary chair in the small dining area of the facilty. R25's hair was uncombed, with her hair flat to the back of her head, with scalp exposed through an uneven part, and her hair stood straight up on the top of her head.

On 3/15/18, at 8:08 a.m. R25 was seated in the small dining area with the activity director present. R25 wore a headband in the front of her hair, however; the back of her scalp was visible through an uneven part, and the hair on the back of her head laid forward on her head. The AD approached R25, cued her to walk with her out of the area, and indicated to R25 they would go to visit other residents in the facility. At 10:09 a.m., R25 was seated in the dining area of the horizons

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unit, watching TV with other female residents present. R25's hair remained uncombed, flat to her head.

On 3/15/18, at 11:23 a.m. nursing assistant (NA)-B stated R25 was usually dressed when staff arrive for the morning shift. NA-B stated R25 was up and dressed for the day when day shift staff arrived on 3/15/18. NA-B verified she had not assisted R25 with cares nor had she combed R25's hair.

On 3/15/18, at 11:26 a.m. NA-F identified the usual assignment of caring for R25 on the morning shift. NA-F indicated R25 was an early riser and routinely had her cares completed by the overnight shit. NA-F verified she had not assisted R25 with cares today nor had she brushed R25's hair or offered to do so. NA-F verified R25's hair was uncombed, and flat to her head.

On 3/15/18, at 1:16 P.M. registered nurse (RN)-B confirmed R25 required extensive staff assistance for areas of daily living including hair care. RN-B stated she would of expected staff to assist R25 with grooming and to comb her hair and to remain neat in appearance through out the day.

On 3/15/18, at 2:21 P.M. the director of nursing (DON) verified staff were expected to comb residents hair, assist with grooming and to help residents to appear neat and clean through out the day. The DON indicated R25's hair should have been combed each day and as needed.

The facility policy titled Resident dignity dated 3/06, identified the facility was to promote care for

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F 676	Continued From page 11 residents in a manner that maintains or enhances each resident's dignity and respect.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper wheelchair positioning was implemented for 1 of 1 residents (R58) observed to have concerns with positioning. Findings include; R58's quarterly minimum data set (MDS) assessment dated 2/27/18, identified R58 had severe cognitive impairment. R58's diagnoses included dementia and seizure disorder. R58's MDS further identified she required extensive assistance with activities of daily living (ADL)s, had a life expectancy of less than 6 months and received hospice services. R58's care plan, reviewed 3/10/18, identified R58 was on hospice and had self care deficit related to cognitive deficits secondary to Alzheimer's disease. R58's care plan listed various interventions which included may use wheel chair	F 684	It is the intent of Glenwood Village Care Center to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices. R58 was referred to OT for wheelchair positioning. OT recommended a different type of wheelchair for resident which hospice did provide for resident. Hospice nurse and RN manager have been in collaboration of care of resident. Resident was dc from OT due goal met. Policy for wheelchair positioning and when to refer to therapy drafted. RN clinical managers educated on policy. Wheelchair positioning will be assessed on all residents that use a wheelchair and referred to therapy as needed. Resident	4/13/18

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F 684	Continued From page 12 at times if R58 was having difficulty ambulating (walking), required extensive assist of two with transfers and reposition every 2 hours when in bed and chair. The care plan listed R58 used a rock and go wheelchair (a rocking wheelchair, with a high back and tilting adjustments). R58's nursing assistant care sheet, undated, listed R58 utilized a mechanical full body lift, staff to reposition her every 2 hours when in bed and chair and extensive assist of two with ambulation. The care sheet did not address the use of a wheelchair and did not address positioning for R58 in the wheelchair. On 3/12/18, at 1:11 p.m. R58 sat in the common area of the unit in her rock and go wheelchair. R58's eyes were closed, head leaned forward towards her chest, with her body and head leaning towards the left side of the wheel chair. R58s feet were on the floor behind the foot pedals rather than on the peddles. R58 held a white wash cloth in her hands and with her mouth open, made soft moaning or snoring sounds. On 3/14/18, at 9:57 a.m. R58 observed seated in rock and go wheelchair at a table in the common area of the facility.. Her trunk leaned to the left side, her left forearm was resting on the seat of the wheelchair. Her eyes were closed,right hand rested on her right cheek and her feet rested on the floor. She was softly moaning, but no grimacing or guarding observed. On 3/15/18, at 11:08 a.m. registered nurse (RN)-B confirmed R58 always leaned to the left side. RN-B confirmed she had not made a referral for R58 for wheelchair positioning. RN-B indicated she felt R58's wheelchair position and	F 684	A.H. referred to OT for w/c positioning. He was given a different w/c. OT continues to work with him. Resident B.J. was referred to OT for w/c positioning. She was given a tilt and space wheelchair. Resident J.F. and H.L. orders just obtained for OT referral for w/c positioning. Resident E.H. waiting on orders from physician for w/c positioning. Audits will be conducted on all new residents x 2 months. Results will be monitored at the Quarterly QA meeting. Responsible Person: Director of Nursing. Corrective Action Completed by: 4.13.18	

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leaning did not cause her discomfort.

On 3/15/18, at 11:21 a.m. occupational therapist (OT)-A confirmed she had not received a referral for R58's wheelchair positioning. She indicated the facility typically did not obtain referrals for residents on hospice services.

In a follow up interview at 1:35 p.m., RN-B confirmed R58 used the same rock and go wheelchair prior to receiving hospice services. She indicated she felt R58's progression of Alzheimer's disease caused her to lean, and R58 lacked trunk support now. RN-B confirmed occupational therapy was not involved with her wheelchair and she had not sent therapy a referral for her positioning. She indicated she felt an evaluation for positioning in the wheelchair would help with her comfort level. RN-B indicated the hospice RN would be in the facility tomorrow and she would ask for orders for a wheelchair positioning referral at that time.

On 3/15/18, at 2:00 p.m. director of nursing (DON) indicated it was the responsibility of the registered nurses to make referrals to therapy if needed. She indicated she would expect a referral would be made to occupational therapy or hospice for positioning, for resident comfort with wheelchair positioning.

The facility draft version policy titled positioning dated 4/20/17, indicated that every resident that was unable to reposition self, would be repositioned at least every 2 hours unless noted differently in the care plan. The policy lacked direction for staff on proper wheelchair positioning or any indication of when and how to make referrals for wheelchair positioning as necessary.

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning to promote healing for 1 of 1 resident (R61) with a current unstageable pressure ulcer. In addition, the facility failed to implement appropriate use of pressure relieving boot for 1 of 1 resident (R40) identified with a current unstageable pressure ulcer on the heel. Findings include: R61's admission Minimum Data Set (MDS) dated 9/18/17, identified R61 had diagnoses which included paraplegia. The MDS identified R61 was cognitively impaired, and required extensive assistance with activities of daily living (ADL)s which included bed mobility, repositioning, locomotion, dressing, and personal hygiene, and total assistance with transfers. The MDS identified R61 was at risk for development of	F 686	It is the intent of Glenwood Village Care Center that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatments and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. R61 ulcer is healed since survey. It was added to Nurses task to check with NAR how many times resident refused positioning and document in nurse notes if resident is refusing positioning. It was added to the NAR task to reposition resident every 2 hours. Task will populate	4/19/18

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pressure ulcers, utilized a pressure relieving device in chair and bed; however, did not identify R61 had a turning/repositioning schedule.

R61's admission Care Area Assessment (CAA) dated 9/20/17, identified R61 had history of stage two pressure injury to her coccyx, was dependent on staff for repositioning and to provide preventative measure to reduce risk, education/compliance evaluation had been done for reposition, off-loading and limited time up in her wheelchair. The CAA identified R61 did not ambulate, was paraplegic, and had right leg below the knee amputation.

R61's form titled Braden Scale for prediction pressure sore risk original (a tool for predicting pressure ulcer risk) dated 2/28/18, identified R61 was "low Risk" for developing pressure ulcers. The form identified R61 had slightly limited sensory perception, was chair fast, had very limited mobility and had a problem with friction and shear.

R61's form titled Tissue Tolerance Testing (tool used to determine the length of time a resident can tolerant being in one position with out risk of skin break down) dated 2/28/18, identified R61 was able to tolerate two hours laying in bed and seated in a chair. The form indicated "off-load every 2 hrs" (hours) would be entered in R61's care plan.

R61's care plan revised 11/8/17, identified R61 had physical disability which included paraplegia, had a potential for pressure ulcer development related to history of coccyx ulcer, had a current pressure ulcer at the right ischial tuberosity (IT) and below the knee amputation, The care plan

F 686

for NAR every hour, if re-approach is needed documentation can be completed. Resident also received a different sling for use with full body lift. Care plan was reviewed by RN Clinical manager and has been updated.

R40 ulcer has healed since survey. WCN saw resident on 3/26/18 and changed orders for left foot boot and changed time of when she would like him sitting up in chair and time to lie in bed. Care plan reviewed and updated. It was added to Nurses task to check with NAR how many times resident refused positioning and document in nurse notes if resident is refusing positioning. It was added to the NAR task to reposition resident every 2 hours. Task will populate for NAR every hour, if re-approach is needed documentation can be completed.
Care plans were reviewed for residents that are at risk for pressure ulcers for appropriate interventions. Repositioning will be added as assessed to the NAR task to reposition residents every 2 hours. Task will populate for NAR every hour, if re-approach is needed documentation can be completed.

Nursing Assistants will be trained at NAR meeting on 4/19/18 at NAR about the need to follow the plan of care and offer repositioning as outlined and to notify charge nurse when resident refuses repositioning.
Audits will be conducted repositioning of residents weekly x 4 weeks.
Audits will be shared at Quality

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listed various interventions which included total assistance of two staff for ADL's, pressure relieving devices in bed and wheel chair, turn/reposition at least every two hours, more often as needed.

Assurance for review and compliance.
Responsible Person: Director of Nursing.
Corrective Action Completed by: 4.19.18

The facility's nursing assistant care guide, identified R 61 required total assist of two staff and a mechanical aid (full body lift) for all transfers; monitoring/reminding/ assistance to turn/reposition at least every two hours, more often as needed or requested.

Continous observations were conducted on 3/14/18, from 7:27 a.m. to 10:50 a.m.:

-At 7:27 a.m. R61 was observed seated in her wheelchair in her room, dressed in street clothes. Nursing assistant (NA)-A propelled R61 in her wheelchair, from her room to a table in the dining room and turned on the nearby television.
- At 7:57 a.m. R61 remained seated at the table in the dining room. Dietary aid (DA)-A approached her, and offered various food choices for the breakfast meal.
-At 8:18 a.m. R61 remained seated in the wheel chair at the table, eating her breakfast meal.
-At 8:45 a.m. R61 remained at the table drinking and handling a napkin.
-At 8:58 a.m. R61 propelled herself towards the hall outside of the dining room.
-At 9:05 a.m. NA-D propelled R61 down the hall, into the center of her room and immediately exited R61's room.
-At 9:41 a.m. R61 remained seated in her wheelchair in her room. Activity aide (AA)-A briefly entered R61's room, offered an upcoming activity, and immediately exited her room. AA-A did not offer repositioning at that time.

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-At 10:02 a.m. R61 remained seated in her wheelchair in her room. NA-A passed R61's room and looked in to the room, however did not speak to R 61 or enter her room.
-At 10:04 a.m. R61 AA-A entered R61's room, propelled R61 to the town center, for the parachute activity with other residents present.
-At 10:19 a.m. R61 remained seated in her wheelchair, in the activity group.
-At 10:36 a.m. R61 remained seated in her wheelchair in the activity. AA-A propelled R61 out of the town center, to her room and positioned her wheelchair next to her over the bed table.

On 3/14/18, at 10:39 a.m. nursing assistant (NA)-A indicated R 61 was paralyzed from the waist down, required extensive assistance of two staff for transferring. NA-A verified he/she had not assisted R61 to reposition today.

On 3/14/18, at 10:46 a.m. NA-D indicated R61 required assistance of two staff to transfer and reposition. NA-D verified R61 had been assisted into the wheel chair this a.m. and had remained in the wheelchair without being laid down, offloaded nor had offered to reposition.

-At 10:50 a.m. R61 remained seated in her wheelchair in her room. NA-D briefly entered R61's room and returned at 10:53 a.m. with NA-D and a mechanical lift. NA-A and NA-D placed the lift sheet under R61 and proceeded to assist her to transfer to bed. NA-A pulled down R61's sweat pants and R61's upper and lower buttocks was observed with deep creases, dark pink, and a large scarred area noted over the buttocks area. A pink colored dressing was observed approximately 4 inches square on the right ischial tuberosity (the area that bears the weight when

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F 686	Continued From page 18 sitting) with a handwritten date of 3/13 on the dressing. R61 had not been repositioned from 7:27 p.m. to 10:53 a.m., a total of 3 hours and 20 minutes. On 3/14/18, 10:56 a.m. NA-A verified R61's dark pink, creased skin on her buttocks and indicated R61's buttocks area had a open area under the pink dressing, which the nurses took care of. Review of R61's Patient Chart Report forms, completed by a wound nurse, from 12/22/17 to 2/28/18 revealed the following: - 12/22/17, a history of muscle flap rotation for a coccyx ulcer, and scars intact. R61 had a open area on her right ischial tuberosity which measured 2.4 centimeters (cm) by 2.2 cm, two areas of dark black necrotic tissue present, no undermining or tunneling noted. Selective wound debridement done at that time. -12/28/17, open area on right ischial tuberosity measured 1.5 cm by 1.0 cm by 0.2 cm deep, 20 percent (%) granulation tissue and 80% yellow slough, small amount or serous drainage, no undermining or tunneling noted. -12/28/17, right ischial tuberosity which measured 1.5 cm by 1.0 cm by 0.2 cm, 20% granulation tissue, 80% yellow slough, no undermining or tunneling noted with small amount serous exudate noted. -1/24/18, open area on right ischial tuberosity, which measured 0.7 cm by 1.2 cm by 0.2 cm, 70 % yellow slough, 30% granulation, no undermining or tunneling. -2/5/18, right gluteal fold open area measured 0.7 cm by 1.0 cm by 0.2 cm, with a discolored area next to the open area which measure 0.5 cm by 1.2 cm. -2/15/18, open area to IT, measured 0.6 cm by	F 686		

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F 686	Continued From page 19 1.0 cm by 0.2 cm. Also noted proximal to the pressure ulcer, a discolored area, which measured 0.5 cm by 1.2 cm. The discolored area was not open at that time. The Wound nurse had recommended staff to make sure the lift sling was removed when not in use, assess clothing to make sure packet stitching did not rest on the area and to assess seated needs in wheelchair. Review of R61's Weekly Wound Documentation Progress Sheets, from 1/10/18 to 3/13/18 revealed the following: -1/10/18, right ischial tuberosity (IT) pressure ulcer present, which measured 1.5 cm in length, 1 cm in width, and had 100% slough, and tan/brown drainage and no change in pressure ulcer. The progress note did not identify a stage of R61's pressure ulcer. -1/17/18, measured 1.5 cm by 1 cm, with superficial depth, 90% slough, 10% granulation, and scant amount of serous drainage and pressure ulcer had worsened. The progress note did not identify a stage of R61's pressure ulcer. -1/30/18, measured 1.7 cm by 1.2 cm , 90% slough, 10% granulation, scant amount of serous drainage, and the pressure ulcer had worsened. The progress note did not identify a stage of R61's pressure ulcer. -2/13/18, measure 1 cm by 0.7 cm, superficial depth, 10% slough, 90% granulation, scant amount of serous drainage and the wound had improved. The progress note did not identify a stage of R61's pressure ulcer. -2/21/18, 1.1 cm by 0.5 cm, scant amount of serous drainage and did not identify if pressure ulcer improved/worsened and did not identify a stage of R61's pressure ulcer. -2/27/18, 0.8 cm by 0.5 cm, superficial depth, 20% slough, scant amount serous drainage, and the wound had improved. The progress note did	F 686		

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not identify a stage of R61's pressure ulcer.
-3/13/18, measured 0.8 cm by 0.5 cm, scant amount of drainage, and pressure ulcer was stable. The progress note did not identify a stage of R61's pressure ulcer.
On 3/14/18, at 12:45 p.m. licensed practical nurse (LPN)-A identified herself as the clinical manager. LPN-A indicated R61 was paralyzed and had no feeling in her lower body. LPN-A identified R61 currently had a pressure ulcer on her buttocks, which was covered with a dressing, and the dressing was changed every three days and as needed. LPN-A indicated staff were expected to turn and reposition R61 every two hours and attempt to work around her activity schedule. LPN-A indicated staff were expected to get R61 up for breakfast last, lay her down after the meal and then get her up again for coffee or bingo. LPN-A verified staff were expected to offer R61 to reposition in order to reduce pressure at least every two hours. She also confirmed R61's current care plan and confirmed staff had incorrectly entered the times R61 was turned and repositioned.
On 3/14/18, at 3:09 p.m. the director of nursing (DON) confirmed R61's care plan and confirmed she expected staff to assist R61 to reposition within two hours. The DON stated the policies provided for skin breakdown were noted as a draft, however; were the current working facility policies.

R40's quarterly Minimum Data Set (MDS) dated 2/2/18, revealed R40 was cognitively intact had diagnosis which included diabetes, depression and weakness. The MDS indicated R40 had a

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F 686	Continued From page 21 stage one or greater pressure ulcer that was unhealed and was at risk for further pressure ulcers. The MDS also indicated R40 had three unstageable pressure ulcers with the largest measuring 7 centimeters (cm) x 5cm and was covered in eschar (black, brown or tan tissue covering the wound bed). The MDS further indicated R40 had pressure ulcers on prior assessment and had pressure reduction devices for chair/bed, was on a turning/repositioning program and was receiving pressure ulcer care with ointments other than feet. Review of R40's Braden Scale for Predicting Pressure Sores form, dated 2/2/18, identified R40 was at mild risk for developing pressure ulcers and identified R40 was slightly limited mobility, could not communicate discomfort or the need to be turned and had potential problem with friction and shearing. Review of R40's Tissue Tolerance Test form, dated 1/23/18, revealed R40 could tolerate a one and half hour repositioning program in chair and in bed. Review of R40's current care plan, revised on 2/2/18, identified R40 had altered skin integrity related to diabetes, neurogenic bladder and macerated skin on coccyx area. The care plan listed various interventions which included pressure relieving mattress, wheelchair cushion and staff to assist R40 to lay down between meals and turn side to side, encourage resident not to lay on back at this time until maceration to coccyx area has healed. However, the care plan did not include directions for pressure relief for R40's current unstageable pressure ulcer.	F 686		

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Review of R40's current nursing assistant Kardex, print date of 3/15/18 indicated R40 required extensive assistance of one to two staff for bed mobility and stand by assistance of one for transfers. The Kardex lacked any direction of when R40 was to be turned repositioned and did not include directions for pressure relief for R40's current unstageable pressure ulcer.

Review of R40's current signed physician orders dated 2/14/18, indicated R40 was to lay in bed and turned from side to side, rest in bed two to three times per day, may only sit up in chair for 30 to 45 minutes (may get up several times per day) and wear blue off loading boot unless transferring or ambulating, every day.

Review of R40's current Treatment Administration Record (TAR) from 2/12/18 to 3/14/18 indicated R40 was to lay in bed and turned from side to side, rest in bed two to three times per day, may only sit up in chair for 30 to 45 minutes (may get up several times per day) and wear blue off loading boot unless transferring or ambulating every shift. Further review of R40's TAR's revealed staff had documented of completion of R40's current intervention as listed above.

Review of R40's orders from the wound care nurse (WCN) noted from 1/24/18 to 3/1/18 revealed the following:

-1/24/18, unstageable to left heel measured 3 centimeters (cm) x 3 cm firm and intact. Wound bed appeared black around the edge with light brown middle, paint left heel with Betadine twice a day, wear off loading boot unless transferring or ambulating, try to lay side to side, rest in bed two to 3 times per day and Betadine to left heel two

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times a day.
-1/30/18, unstageable to left heel measured 2.5 cm x 3 cm, wound black area around the edge with brown middle. Will continue to paint left heel with Betadine twice a day, wear off loading boot unless walking with physical therapy or transferring and reposition side to side. may sit up in chair for 30 to 45 minutes, may get up and down several times per day
-2/5/18, left heel remains dark and firm, measures 2.5 cm x 3 cm with darker area in middle measuring 0.8 cm x 0.8 cm, edges attached, covering of dark brown to black eschar. Will continue Betadine to area, wear off loading boot except when working with therapy or transferring and encourage patient to only sit up 30 to 45 minutes at a time and may get up several times through out the day.
-2/15/18, left heel measured 1.2 cm x 1.0 cm black, firm eschar does peel off easily today revealing a small area of redness. Will continue Betadine paints, offloading of areas and repositioning.
-2/23/18, left heel 1 cm x 0.5 cm scabbed.
- 3/1/18, left heel pressure injury measured 0.4 cm x 0.3 cm as well as 0.3 cm x 0.2 cm x 0.1 cm, wound edges are attached and wound bed covered by firm dark brown eschar. Will continue to paint area with Betadine and continue to reposition patient frequently as well limiting in his chair to 45 min to hour when possible will follow

During observations on 3/14/18 at 7:59 a.m. R40 was seated at the dining room table in his wheelchair wearing black leather shoes on both feet, his shoe covered feet rested directly on the foot pedals of his wheelchair.
- 8:16 a.m. R40 remained seated in his wheelchair at the dining room with his black

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leather shoes on both feet.
-8:28 a.m. R40 remained seated in his wheelchair at the dining room with his black leather shoes on both feet.
- 9:00 a.m. R40 remained seated in his wheelchair at the dining room with his black leather shoes on both feet.
- 9:27 a.m. nursing assistant (NA)-E approached R40, applied a gait belt to his waist and assisted him to walk the entire length of the hallway to his room, using a front wheeled walker, with his black leather shoes on both feet. R40 sat down in his wheelchair and went to play cards with his wife and friends in Ruby Ridge room.
-11:57 a.m. R40 was seated in his wheelchair in his room, both shoe covered feet rested on the pedals of the wheelchair with NA-G present. NA-G applied a gait belt to R40's waist and assisted him to walk from his room, down to the dining room via walker.

During observation on 3/14/17 at 2:12 p.m. R40 was laying on his back in bed, with black leather shoes on both feet and NA-G present in the room. NA-G removed R40's black leather shoes and socks from him feet, when RN-A entered the room. NA-G held R40's left foot while RN-A measured the unstageable ulcer on his left heel: the ulcer measured 1 cm round, with dry flaky skin noted on the outer edges of the ulcer. RN-A proceeded to apply a brown liquid to R40's left heel.
-2:19 p.m. NA-G applied R40's blue offloading boot, from the seat of his recliner, to R40's left foot.
-at 2:23 p.m. RN-A had R40 roll to his left side, pulled down R40's pants and brief. R40 was noted to have two areas on right side crease of coccyx area measured 2 cm x 1 cm and 3.5 cm x

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F 686	Continued From page 25 2 cm that were dark purple/pink in color, blanchable and was currently not open. RN-A proceeded pull up R40 brief and pants, rolled R40 to his right side, placed a pillow behind his left back, a pillow between his knees, with the blue boot present on his left foot. On 3/14/18 at 2:19 p.m. R40 indicated he originally got the sore on his heel from his stocking sliding in his shoes, then went to a heavier sock and blue boot to left heel and it had gotten better. He stated he wore the blue boot while he was in bed and indicated he felt the ulcer had gotten worse while he was in the hospital. On 3/14/18 at 2:33 p.m. during a group interview, RN-A and NA-G confirmed R40 had an unstageable ulcer to his left heel and indicated R40 was to wear his off loading blue boot only while in bed. RN-A and NA-G confirmed R40 had not worn his blue off loading boot all day and had remained in his wheel chair, not laid down, for the entire shift. On 3/14/18 at 12:32 p.m. NA-E confirmed R40 had a current pressure ulcer on his left heel and required extensive assistance of one staff for transfers and ambulation with walker. NA-E indicated R40 had a blue off loading boot in his room and he was to wear it when he laid down in bed. NA-E also indicated R40 was to lay side to side when in bed, and indicated in the past R40 used to get up for an hour then lay back down for an hour. NA-E indicated R40 did not follow that routine consistently and currently was not doing this anymore. On 3/14/18, at 1:51 p.m., during a follow up interview, RN-A indicated she thought R40 was to	F 686		

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F 686	Continued From page 26 wear the blue off loading boot to relieve pressure while he was in bed. RN-A verified R40 was to be repositioned and was limited to be up in his wheel chair for 30 to 45 minutes at a time and turn side to side in bed. RN-A indicated R40 was pretty good about being compliant with cares and thought the WCN had directed staff to have R40 wear his shoes during the day, to wear the blue off loading boot only when in bed. On 3/14/18 at 2:55 p.m. RN-C confirmed R40 currently had a pressure ulcer on his left heel and was at risk for further pressure ulcers. RN-C verified R40's current orders from the WCN and primary physician to wear his blue off loading boot at all times except for when he is ambulating or transferring and to be up in his wheelchair for 30 to 45 minutes at a time. On 3/15/18 at 8:49 a.m., during a follow up interview, RN-C verified R40's current care plan, TAR and indicated the care plan had not been updated to reflect R40's current orders. RN-C indicated R40's interventions had been put on the TAR instead of the care plan. RN-C indicated her expectation of staff would be to follow the care plan and Kardex. RN-C indicated she expected staff to follow the orders as written for R40, for blue off loading boot at all times and repositioning. On 3/14/18 at 3:00 p.m. via telephone interview, the WCN confirmed R40 returned from the hospital with a pressure ulcer on his left heel. The WCN indicated she would expect staff to follow her orders as written and have the interventions in place. The WCN indicated R40 should be up in his chair 30 to 45 minutes only and should have his blue off loading boot on his left foot at all	F 686		

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F 686	Continued From page 27 times unless transferring or ambulating to prevent further pressure ulcers. During observations on 3/15/18 at 10:28 p.m. R40 was seated in his wheelchair in his room talking with his wife, and wore black leather shoes on both feet. R40's blue off loading boot was observed on the seat of his recliner in his room. -1:19 p.m. RN-A indicated R40 was out to a dental appointment with his wife. R40's blue off loading boot remained on the seat of his recliner in his room. -2:09 p.m. R40 was seated in his wheelchair at the dining room table and continued to wear his black leather shoes on both feet. On 3/15/18 at 3:06 p.m. director of nursing (DON) indicated R40 currently had a left heel pressure ulcer and staff were currently monitoring it and had a previous pressure ulcer on his buttocks area. She confirmed R40 was at risk for development of further pressure ulcers. The DON indicate she expected staff to follow the orders as written by the WCN and indicated she knew she had problems on this wing with care plan's not getting updated and revised. The facility policy titled Prevention and Treatment of Skin Breakdown revised 4/4/17, identified the facility would identify, assess, implement preventative measures, provide appropriate treatment modalities for wounds according to industry standards of practice.	F 686		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services.	F 790		4/18/18

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F 790	Continued From page 28 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by:	F 790		

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F 790	Continued From page 29 Based on observation, interview and document review the facility failed to ensure that dental services were provided as necessary for 1 of 1 resident (R 55) reviewed with missing, broken teeth. Findings include: 55's admission Minimum Data Set (MDS) dated 2/22/18, indicated R 55 was moderately cognitively impaired, had diagnoses which included dysphagia, cerebral infarction and pneumonia. The MDS indicated R 55 needed extensive assistance of two staff with all activities of daily living and required assistance of one staff for eating. R 55's admission Oral Assessment dated 2/15/18, indicated R 55 had upper dentures, broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). R 55's current care plan revised on 3/14/18, indicated R 55 had bottom teeth and partial upper plate and mouth cares to be provided every hour. The care plan also indicated R 55 had tube feeding related to dysphagia, swallowing problems due to cerebral vascular infarction (stroke). The care plan listed various interventions which included: speech therapy upgrade to honey thickened liquids and pureed textures. Review of R 55's Consent Form dated 2/15/18, indicated R 55 gave consent for a dental appointment. The form listed if the form was not returned, that would be taken as a decline for annual dental services, and no further attempt for dental services would be made unless	F 790	It is the intent of Glenwood Village Care Center to provide routine and emergency dental services for all residents according to federal and state guidelines. The resident involved saw the dentist on 3/19/18. This visit his upper denture was sent out to be relined and lower partial was adjusted. He returned to the dentist on 4/4/18 and upper denture was returned to him and fit. He is to return if sores noted and to return May 17 for cleaning and filling. All new residents will continue to be assessed for dental needs. Will review all current residents dental needs and refer to dentist as needed. New resident s charts will be audited for dental needs and that a plan of action is in place if resident is requesting dental needs. Audits will be conducted x 2 months. Dental policy/procedure that follows federal and state guidelines was reviewed and revised. Policy will be reviewed with nursing staff at nurses meeting on April 18. Results will be monitored at the quarterly QAA meetings. Responsible Person: Director of Nursing. Corrective Action Completed by: 4.18.18	

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F 790	Continued From page 30	F 790		

emergency services were needed. No further documentation regarding R 55's request for dental services was found on the form.

On 3/12/18 at 1:27 p.m. R 55 was sitting in his wheelchair in his room watching television. R 55 had no upper teeth and had some natural teeth on the bottom that were yellow /gray in color and in bad repair. At this R 55 indicated he had an upper plate but they did not fit anymore and would fall out. R 55 indicated he felt the facility staff was aware of this and felt they were not working on getting his dentures fixed.

During observation on 3/14/18 at 8:15 a.m. R 55 was sitting in his recliner in his room and receiving feeding feedings via peg tube. R 55 had no upper dentures in his mouth and natural teeth noted on the bottom of his mouth. At this time R 55 indicated he did not wear his dentures because they don't fit right.

During observation on 3/15/18 at 9:53 a.m. R 55 was seated at the dining room table in his wheelchair and was eating breakfast. R 55 had nectar thickened orange juice, toast crumbs, oatmeal, pureed banana and was eating independently with staff sitting next to him. R 55 had no upper dentures in his mouth while he ate his breakfast independently.
-at 9:59 a.m. R 55 indicated his upper dentures did not fit and stated "they fall out." R 55 indicated that he needed to get his dentures fixed and had not been to a dentist recently to get them fixed.
-at 10:22 a.m. R 55 continued to eat his breakfast with no upper dentures.

On 3/15/17 at 9:55 a.m. trained medication aid (TMA)-A indicated R 55 needed supervision with

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F 790	Continued From page 31 oral cares and had upper dentures but was not sure why R 55 did not wear them. TMA-A verified R 55 had not been wearing his upper dentures. On 3/15/18 at 10:14 a.m. occupational therapy rehab (OTR) confirmed they are currently working with R 55 on his activities of daily living and indicated R 55 was independent with oral cares after set up help. The OT indicated R 55 had not been wearing his upper dentures and did not know why he did not wear them. On 3/15/18 at 10:36 p.m. registered nurse (RN)-C indicated she was not aware R 55 was having problems with his upper dentures and verified R 55 did not have an appointment set up to see the dentist in the near future. RN-C indicated she was unaware R 55 ever had upper dentures. On 3/15/18 at 3:01 p.m. director of nursing (DON) indicated staff should of followed up on R 55's request to receive dental care and should of gotten his dentures fixed. The DON indicated she felt his teeth was not a problem while he was receiving feeding via peg tube and he did not need them. The DON indicated speech therapy should of assessed R 55 for his dentures and would expect staff to follow up on R 55's dental needs. Review of facility policy titled, Dental Services revised on 5/4/17, indicated Glenwood Village Care Center will provided routine and emergency dental services to all residents per state and federal guidelines. Annual dental letters will be sent out to resident or appointed responsible party in August of each year.	F 790		
F 804	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		4/19/18

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F 804 SS=E	Continued From page 32 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 12 of 12 resident (R54, R3, R16, R29, R35, R11, R33, R8, R27, R22, R34, R40) who had food concerns. Findings include: On 3/13/18 at 1:48 p.m. a resident council meeting was held and the following residents attended the meeting R54, R3, R16, R29, R35, R11, R33, R8, R27, R22, R34, R40. During the meeting the following concerns were voiced: -residents voiced concerns that a snack cart was not available and staff only provided snacks at times if residents asked for them. The residents indicated the only time they were offered snacks was for the Bingo activity. -residents voiced concerns about food being cold, indicated they would send the cold food back to the kitchen, would be reheated and indicated the food was not very appetizing then. The residents indicated the food was barely warm at times, but	F 804	It is the intent of Glenwood Village Care Center is to provide food and drink that is palatable attractive, and at a safe and appetizing temperature. The Dietary Director held a dietary staff meeting on 4/10/18 to educated staff on what proper food temperatures are and also proper ways of taking food temperatures. We also discussed that tray audits will be performed to ensure proper temperatures of food at time of service on households. These audits will be done weekly x 4 weeks at varying meal times. Additional test trays will be completed as needed based on resident complaints identified from resident comments or Food Council. Handouts were given at this meeting related to our test tray policy and proper food temperatures. This repeat session will be held again on 4/17/18 for those that did not attend the previous meeting. Individual meeting will be set up for those that did not attend either one of these meeting. Audits will be shared at monthly QAPI meeting and quarterly QA meeting for	

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F 804	Continued From page 33 most of the time the food was cold. -residents voiced concerns they did not know what a grievance was and was not sure how to file a grievance. Review of Resident Council Minutes and Food Council Minutes from 8/17 to 2/18 revealed the following: -8/15/17, residents voiced concerns vegetables were cold. -9/17, no food council meeting. -10/24/17, residents voiced concerns about carrots being cold, staff not going around offering bedtime snack and food not hot enough on the evening meal. -11/22/17, residents voiced concerns about bedtime snacks not being offered at all and food not hot enough on the evening meal. -12/27/17, residents voiced concerns about food not hot enough on the evening meal. -1/31/18, residents voiced concerns about food not hot enough and wanted the food served hotter. -2/28/18, residents voiced concerns about cold food on Blue Horizon wing and especially the soups. Food council notes indicated the food was not hot enough on all households during the evening meals. On 3/12/18 at 5:46 p.m. during observations on	F 804	review and compliance. Person responsible for correction: Judy Mattocks, CDM Dietary Director Corrective Action Completed by: 4.19.18	

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F 804	Continued From page 34	F 804		

Blue Horizon wing, dietary cook (DC)-A was serving different kinds of pizza and salad for the supper meal. While serving, DC-A had a large, uncovered silver cookie sheet which held various types of pizza, on top of the steam table serving pizza to the residents. The silver cookie sheet was not receiving direct heat from the steam table unit while pizza was being served to the residents. DC-A continued to serve pizza in this manner, until she was done serving the supper meal at approximately 6:00 p.m. At 6:02 p.m. while the residents were eating, R27 indicated her pizza tasted good but was only warm. R40 indicated his pizza had good flavor, but was warm only and R8 indicated her pizza was cold.

On 3/14/18 at 12:17 p.m. a test tray was requested from DC-B. The meal consisted of mashed potatoes with gravy, meatballs, sweet and sour pork, oriental vegetables and rice. The mashed potatoes and gravy were warm, not palatable and lacked flavor. The meatballs were warm on the outside and cold on the inside of the meatball, but had good flavor. The sweet and sour pork with rice were cool, had good flavor and oriental vegetables were cold and not palatable. DC-B was asked to temp the food listed above while it remained on the steam table, the temps were as follows:
-potatoes with gravy's temperature: 120 degrees Fahrenheit (F)
-meatballs with gravy temperature: 90 degrees F
-sweet and sour pork temperature: 98 degrees F
-rice temperature: 130 F
-oriental vegetables temperature: 91 degrees F

DC-A indicated he was not aware the residents complaining about the food being hot enough on the day shift, but was aware of complaints of cold

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F 804	Continued From page 35 food on the evening shift. DC-A confirmed the above findings of improper temperatures of food, and confirmed the steam table was plugged in and working. DC-A indicated staff only turn on the steam table on while meals were served to the residents. On 3/14/18, at 12:24 p.m. resident dining was observed and R27, R42 and R40 had finished consuming the meal. At that time, R27 stated the sweet and sour pork, rice and oriental vegetable, had good flavor, "but could of been warmer." R42 stated the meatballs and sweet and sour pork was warm only, and stated the food items could of been hotter. R40 stated the meatballs, sweet sour pork, oriental vegetables was "cold." R40 stated staff had reheated his food items twice that day and he had not eaten the meatballs or oriental vegetable because their were "cold." On 3/13/18 at 2:41 p.m. DM confirmed she was aware of the resident complaining about food being cold. The DM indicated she had educated a few of her staff members about cold food in the past. The DM indicated she was only aware of the residents having concerns mostly about the supper meal and she was aware of complaints before Christmas time. The DM indicated her expectation of staff were to serve quality hot food and restaurant style service. DM confirmed the food temperature on the steam tables were considered in the "danger zone" if the food temperatures were not kept above 140 degrees. The DM indicated that she had not ever checked the temperature on the steam tables after serving a meal was complete to see if the food was at appropriate temperature. The DM indicated her expectation of staff were to make sure the food was hot and served at the proper temperatures.	F 804		

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F 804	Continued From page 36 The DM indicated if the food was not hot enough then it should be reheated and the temperatures should be rechecked to get to a minimum temperature of 165 to 180 degrees F. The DM indicated she felt staff needed more education in proper food temperatures. On 3/13/18 at 3:04 p.m. nursing assistant (NA)-C indicated she works on all the units in the facility and indicated she had heard the residents complain about cold food at least once a week and indicated the complaints were pretty wide spread through out the facility. NA-C indicated she would try to offer the residents something else or would try to warm up their food for them. NA-C indicated she was aware a lot of residents were frustrated and indicated she felt the residents had the right to be. On 3/15/18 requested facility policy in regards to proper food temperatures and palpability, one was not provided.	F 804		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		4/20/18

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	245402	A. BUILDING _______ B. WING _______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD VILLAGE CARE CENTER	**719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334**

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F 883	Continued From page 37 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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F 883	Continued From page 38 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R12, R25)received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The Center for Disease Control and Prevention identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R12 was a 92 year old admitted to the facility in 2016. Review of the facility form titled Immunization Report with a date range of 2/1/2003, - 3/31/18, indicated R12 had received a Pneumococcal conjugated (PCV13) immunization on 2/6/2003, and the PPSV23 immunization on 2/6/2009. However, the conjugated (PCV13) immunization was not available for use until 2/24/2010. R25 was a 91 year old admitted to the facility in 2017. Review of the facility form titled Immunization Report with a date range of 1/1/1999, - 3/15/18, indicated R25 had received a Pneumococcal conjugated (PCV13) immunization on 12/22/2016, however; had not received the PPSV23 immunization. R25's clinical immunization report lacked documentation as to why R25 had not received a PPSV23	F 883	It is the intent of the Glenwood Village Care Center that each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized. Record review was done with MIIC for R12 and no record Prevnar 13 was given. Followed up with medical records at residents clinic and no records indicated she has had the immunization. Consent and physician order were received for R12 to receive the prevnar 13immunization and immunization was administered. Record review was done with MIIC for R25. MIIC Website records indicate resident is up to date on Pneumococcal immunizations. Information was recorded In resident s chart. All residents charts will be reviewed for for the offering of PCV13. All residents who qualify for the PCV13 vaccination will be offered and vaccination	

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F 883	Continued From page 39 immunization. On 3/15/18, at 4:55 p.m. after review of nursing home and clinic immunization records, Registered nurse (RN)B verified the PCV13 was not in distribution prior to 2010 and agreed R12 and R25 lacked the recommended Pneumococcal immunizations. On 3/15/18, at 5:16 p.m. the director of nursing (DON) verified staff should have followed up on R12 and R25's immunization records. The DON indicated the facility's usual practice was to offer needed immunizations. The facility policy titled Immunization, revised on 3/23/2017, directed upon admission a review of immunization history would be completed and residents would be offered immunizations according to the current CDC recommendations. The policy directed both PCV13 and PPSV23 immunizations to be administered to all adults aged 65 and older for the prevention of Pneumococcal disease.	F 883	will be administered if the resident so desires. If declined it will be documented according to policy. Upon admission residents will be assessed for the need of the pneumococcal vaccination (PCV13) per CDC guidelines. PCV13 will be offered and administered if the resident agrees. Education will be given at the time of the offer of the vaccination explaining the risk versus benefits of the vaccination. RNs educated on Pneumococcal Policy and Procedure. Audits on all new residents for the administration of the PCV13 will be completed on all admissions x 2 months. Completion for the administration of the PVC 13 will be completed by 04/20/18. Results will be reported Quarterly QAA meeting by DON. Responsible person: Director of nursing. Corrective Action Completed by: 4.20.18	

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

F5402027

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/12/2018**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Glenwood Village Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Glenwood Village Care Center was constructed at five different times. The original building was built in the 1962, is 1- story, with a partial basement and was determined to be of a Type II (111) construction. In 1975 an addition was added to the northeast that was determined to be Type II (111) construction. In 1978 an addition was added to the southeast that was determined to be Type II (111) construction. In 1987 an addition was added to the west that was determined to be Type II(111). In 2014 the 1987 addition was renovated into a 15 bed southwest wing. Type II (III) construction. The building is divided into 6 smoke zones on the main floor. The facility is now surveyed as one facility. An automatic sprinkler system is installed throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces. Also, the facility has battery powered smoke detection in all resident sleeping rooms. The fire alarm is monitored for automatic fire department notification.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 The facility has a capacity of 64 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		