#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		ICARE/MEDICA		ID: 8EZ1 Facility ID: 00672			
1. MEDICARE/MEDICAID PROVIDE (L1) 245345 2.STATE VENDOR OR MEDICAID NO (L2) 100182500	R NO.	3. NAME AND AD	DRESS OF FACILIT HEALTH CENT DAVENUE NORT	TY T <b>ER OF GF</b>	REENWOOD PRAIRIE (L6) 55964	4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint	
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
<ul> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited</li> <li>1 TJC</li> <li>2 AOA</li> <li>3 Other</li> </ul>	/11/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOW         18 SNF       18/19 SN		B. Not in Com	ce With equirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director	
53 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA See Attached Remarks	RKS (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE	nit Supervisor	Date :	02/26/2014	(110)	18. STATE SURVEY AGENCY AP Mark Meath, Enfo	Drcement Specialist 04/23/2014	
	PART II - TO	BE COMPLETE	D BY HCFA RE	(L19) EGIONAI	OFFICE OR SINGLE STAT	(L20) E AGENCY	
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to</li> <li>2. Facility is not Eligible</li> </ol>	Participate		IPLIANCE WITH C ITS ACT:	IVIL	<ol> <li>Statement of Financial</li> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION <b>09/01/1986</b>	BEGINNING	DATE	ENDING DATI	Ξ	VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION ( 03/18/2014	OF APPROVAL DAT	ΓE			
	(L32)	50/10/2014		(L33)	DETERMINATION APPRO	VAL	

DEPARTMENT OF HEALTH AND HUN	1AN SERVICES	<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>				
	MEDICARE/MEDICAID CERTIFICATION AND TRAN	SMITTAL	ID: 8EZ1			
	PART I - TO BE COMPLETED BY THE STATE SURVE	YAGENCY	Facility ID: 00672			
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS					

#### CCN 24-5345

St Isidore Health Center of Greenwood Prairie was not in substantial compliance with Federal participation requirements at the time of the December 19, 2013 standard survey. February 3, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on February 11, 2014, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the December 19, 2013, effective January 28, 2014. Refer to the CMS-2567b for both health and life safety code.

Effective January 28, 2014, the facility is certified for 53 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

February 26, 2014

Ms. Paula Lewis, Administrator St Isidore Health Center Of Greenwood Prairie 800 Second Avenue Northwest Plainview, MN 55964

RE: Project Number S5345023

Dear Ms. Lewis:

On January 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 11, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2013, effective January 28, 2014 and therefore remedies outlined in our letter to you dated January 16, 2014, will not be imposed.

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

Sincerely,

Sary gederhoff

Gary Nederhoff, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245345	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 2/3/2014		
Name of Facility			Street Address, City, State, Zip Code			
ST	ISIDORE HEALTH CENTER OF GREEN	WOOD PRAIRIE	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964			

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0309		01/28/2014		ID Prefix	F0323		01/28/2014		ID Prefix	F0329		01/28/2014
0	483.25					483.25(h)					483.25(I)		_
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0431		01/28/2014		ID Prefix	F0465		01/28/2014					
•	483.60(b), (d), (e)				•	483.70(h)				Reg. #			_
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
			Correction					Correction					Correction
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ID Prefix			- F		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
Reviewed By	/ Rev	iewed B	5y	Da	te:	Signature o	f Surve	yor:				Date:	
State Agency	y M	IM/G	N	02	2/26/20	14		10	0160	)		02/0	3/2014
Reviewed By	/ Rev	iewed B	<sup>B</sup> Y	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed						•				a Summary of		
	12/19/20	13				Unc	orrecte	a Deficiencies		5-2567) Sent	to the Facility?	YES	NO

Form Approved

OMB NO. 0938-0390

Form Approved

OMB NO. 0938-0390

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245345	(Y2) Multiple Constr A. Building B. Wing		N BUILDING 01	(Y3) Date of Revisit 2/11/2014			
Name	of Facility			Street Address, City, State, Zip Code				
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE				800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964				

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

(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction				Correction					Correction
ID Prefix			Completed 01/28/2014		ID Prefix		Completed		ID Prefix			Completed
	NFPA 101				Dec. #				Reg. #			
•	K0144											
							·					
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
Reg. #					Reg. #		-		Reg. #			
LSC					LSC							
			<b>a</b>									<b>0</b> //
			Correction Completed				Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix				ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix				ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix							-					
Reg. # LSC					Reg. # LSC				Reg. #			
				<u> </u>								
Reviewed By	Review	ved E	Зу	Da	te:	Signature of Surve	yor:				Date:	
State Agency	y MN	Л/Р	S		02/26/14	25	5822				02/	11/14
Reviewed By	/ Review	ved E	Зу	Da	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed on	:				Check for any				•		
	12/18/2013					Uncorrecte	d Deficiencies	(CMS	5-2567) Sent t	o the Facility?	YES	NO

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245345	(Y2) Multiple Constru A. Building B. Wing	uction 02 - CHA	PEL	(Y3) Date of Revisit 2/11/2014			
Name of Facility				Street Address, City, State, Zip Code				
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE				800 SECOND AVENUE NORTHWE PLAINVIEW, MN 55964	ST			

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

(Y4) Item		(Y5)	Date	(Y4)	ltem	(Y5)	Date	(Y4)	ltem	(	Y5)	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			01/28/2014		ID Prefix		-		ID Prefix			
-	NFPA 101				Reg. #				Reg. #			
LSC	K0144								LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC									LSC			_
			Correction				Correction					Correction
			Completed				Completed					Completed
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Reg. #					Reg. #							
LSC					LSC				LSC			_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			completed		ID Prefix		•		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			_
Reviewed By	Rev	viewed B	у	Da	te:	Signature of Surve	yor:	- 1			Date:	
State Agency	y M	IM/PS	02/2	6/2	2014	10	160					
Reviewed By	/ Rev	viewed B	у	Da	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed	on:				Check for any				-		
	12/18/20	13				Uncorrecte	d Deficiencies	s (CMS	-2567) Sent t	o the Facility?	YES	NO

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES	
					AND TRANSMITTAL	ID: 8EZ1	
1. MEDICARE/MEDICAID PROVID		3. NAME AND AL			TE SURVEY AGENCY	Facility ID: 00672 4. TYPE OF ACTION: <b>2</b> (L8)	
(L1) <b>245345</b>					F GREENWOOD PRAIRIE	1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID N (L2) 100182500	NO.	(L4) 800 SECON (L5) PLAINVIEV		ORTHWE	(L6) <b>55964</b>	3. Termination4. CHOW5. Validation6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 12/19	<b>9/2013</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia				The Following Requirements:	
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director	
12.Total Facility Beds	<b>53</b> (L18)	1. A	cceptable POC		<ol> <li>4. 7-Day RN (Rural SN</li> <li>5. Life Safety Code</li> </ol>	IF)8. Patient Room Size 9. Beds/Room	
13.Total Certified Beds	<b>53</b> (L17)	X B. Not in Com Requireme	ppliance with Progents and/or Appli			(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
53 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Michele McFai	rland, HFE NE	<u>II</u> 0	1/30/2014	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 03/18/2014	20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBIL	JTY		IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	
<b>X</b> 1. Facility is Eligible to F	•				3. Both of the Above		
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEM	MENT 24	I. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> 00	INVOLUNTARY	
09/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimburs	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	n	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			04-Other Reason for Withdrawal	07-Provider Status Change	
	A. Suspension	i of Admissions.	(L44)			00-Active	
(L27)	B. Rescind Su	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)	03/18/2014		(L33)	DETERMINATION APPI	ROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	<b>CENTERS FOR MEDICARE</b> &	& MEDICAID SERVICES
MEDICARE/MEDICAID CERTIFICA	TION AND TRANSMITTAL	ID: 8F71

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN

24-5345 At the time of the Standard survey on December 19, 2013, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the 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), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Facility ID: 00672



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3902

January 16, 2014

Ms. Paula Lewis, Administrator St Isidore Health Center Of Greenwood Prairie 800 Second Avenue Northwest Plainview, Minnesota 55964

RE: Project Number S5345023

Dear Ms. Lewis:

On December 19, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

# DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

# **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 January 28, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 28, 2014 the following remedy will be imposed:

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

# PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

#### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by March 19, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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

Services that your provider agreement be terminated by June 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

# Mark Meath

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

Enclosure

cc: Licensing and Certification File

5345s14.rtf

		AND HUMAN SERVICES			FORM	: 01/16/2014 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION JAN 2 9 2014	(X3) DAT	. 0938-0391 TE SURVEY MPLETED
		245345	B. WING	MN Dept of Health Rochester	12	/19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STISIDO	RE HEALTH CENTER	R OF GREENWOOD PRAIRIE		800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000 F 309 SS=D	as your allegation o Department's accept bottom of the first p be used as verificat Upon receipt of an a revisit of your facility validate that substa regulations has bee your verification. 483.25 PROVIDE C HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psycho	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with CARE/SERVICES FOR EING receive and the facility must ary care and services to attain test practicable physical,	F 000	admission that a deficiency exists or that statement of deficiency was correctly cite Preparation and submission of this plan correction does not constitute an admiss agreement of any kind by the facility to th of any facts alleged or the correctness of conclusions set forth in the allegation by survey agency. Preparation and submiss of this plan of correction has been done comply with the requirements of state an federal law that mandate submission of a Plan of Correction within ten (10) days of	al this ed. of ion or ne truth any the ion d the s a ithe s a itle 19 acility's	
	by: Based on observation review, the facility factor of 3 residents (R36) investigate, assess, promote healing and reoccurring for 1 of non-pressure related Findings include: R36 was observed of have a dark purple of DIRECTOR'S OR PROVIDE	on 12/16/13, at 3:50 p.m. to discolored area located on the ER/SUPPLIER REPRESENTATIVE'S SIGN	- R	TITLE		(X6) DATE 2012014
other safegua following the o	rds provide sufficient prot date of survey whether or g the date these documen	ection to the patients. (See instructions not a plan of correction is provided. For	<li>Except for or nursing hor</li>	on may be excused from correcting providing nursing homes, the findings stated above ar nes, the above findings and plans of correction re cited, an approved plan of correction is re	e disclosa	ble 90 days

program participation.

# Attachment 1

# Regulation 483.25 Tag F309 Provide Care/Services for Highest Well-being

JAN Dept of Health

St. Isidore Health Center of Greenwood Prairie provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. A plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments.

The policies and procedures for reporting, investigating, and monitoring bruises and other skin lesions were reviewed and found appropriate. Facility policies require that the licensed nurses conduct a comprehensive skin audit at the time of admission, upon readmission from the hospital, and after falls and other incidents that put the resident at risk for injury. The nursing assistant bathing protocol includes observing and reporting open skin areas and bruises.

During the January 16, 2014 mandatory meetings, the licensed nurses were instructed on skin-related policies and procedures including 1) the procedures for investigating, documenting, and tracking bruises and 2) the need to mentor the nursing assistants to be alert to bruising and open areas and to appropriate reporting of findings to the licensed nurse. During the January 23, 2014 mandatory meetings, the certified nursing assistants were instructed to be observant for open skin lesions and bruises and to report findings to a licensed nurse in a timely manner.

**Resident number 36** - The resident's skin was reassessed by a registered nurse. The bruise on the resident's temple has healed without complication. The January 10, 2014 registered nurse note indicated no temple tenderness when rubbing scalp or combing hair. The resident's skin-related plan of care was reviewed and found appropriate/updated.

**Resident number 6** - The resident's skin was reassessed by a registered nurse including the discolored area on the resident's right hand. The cause of the bruise on the resident's was investigated by a licensed nurse and felt to be caused by the resident's hand-to-wrist orthotic used to prevent contractures and preserve functional range of motion. A physical therapy evaluation of the orthotic was requested. Occupational therapy has been working with the resident since admission and recently reeducated the staff on adjustment of the hand orthotic. The resident's related plan of care was reviewed and updated.



The resident has chronic skin discolorations/lesions related to fraility and has increased risk of bruising due to receiving aspirin on a daily basis. Routine skin assessments will continue; concerns will be reported to the attending physician. The care plan has been reviewed and updated.

Compliance will be monitored by the RN Clinical Manager/designee by conducting random skin audits for two weeks. If previously unreported bruises or other skin problems are observed, additional auditing and staff training/counseling will be done. The results of the audits will be reviewed during the January Quality Council meeting and ongoing.

Completion date: January 28, 2014

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′		ECONSTRUCTION JAN 2 9 2014		E SURVEY IPLETED
		245345	B. WING		Rochester	12/	19/2013
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 12/	10/2010
ST ISIDC	RE HEALTH CENTER	OF GREENWOOD PRAIRIE			00 SECOND AVENUE NORTHWEST LAINVIEW, MN 55964		
0(0.15		TEMENT OF DEFICIENCIES	l		PROVIDER'S PLAN OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
						-	
F 309	documented evident identified, ongoing a develop intervention assessment to prev The annual Minimur indicated R36 had o dementia, anxiety a indicated R36 had o and a history of falls 10/2/13 identified R bruising related to p The November 201 indicated on 11/29/ unwitnessed fall. A identified R36 had a and right side of he documentation the the area monitored complications. On 12/19/13, at 9:2 (DON) verified the R temple of R36 and and confirmed R36 her head. DON verified the R temple of R36 and and not been identii DON stated when a in an injury, DON ez monitoring event" ir to ensure monitorin	<ul> <li>apple. The clinical record lacked lace the discoloration had been assessment for healing, and his based on a comprehensive rent bruising from reoccurring.</li> <li>apple. The Alted 9/27/13, diagnoses to include ind heart disease. The MDS severe cognitive impairment is. R36's care plan dated 36 as having a risk for oaper thin skin.</li> <li>3 nursing progress notes 13, R36 had sustained an lthough the progress note a bump on the right forehead ad, the clinical record lacked bruise had been identified and for healing without</li> <li>5 a.m. the director of nursing progress recent fall had bumped the right side of fied the bruise from the fall fied in R36's medical record. A fall occurred which resulted xpected the nurse to "open a n the resident's clinical record g of the injury was completed.</li> </ul>	F 3	09	Please see attachment #1		1/28/2014
	created nor was the The Skin Risk Asse	essment policy dated 7/2013, e and document the absence					

Event ID: 8EZ111

Facility ID: 00672

If continuation sheet Page 2 of 25

		AND HUMAN SERVICES			FO	ED: 01/16/2014 RM APPROVED NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	.TIP	PLE CONSTRUCTION	DATE SURVEY COMPLETED
		245345	B. WING		MN Dept of Health Rochester	12/19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
ST ISIDO	DRE HEALTH CENTER	R OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	R6 had a bruise loc had not been report assessed for causa in place to promote bruising. R6 was observed on have a purple colore between the second hand. R6 wore an o the bruised area. R6 how and when the b On 12/18/13, at 10:2 the hand to wrist ort bruise on the right h Velcro from the right h Velcro from the right the observation, R6 "hurt." The quarterly Minim 10/13/13, indicated failure, hypertension and hemiplegia of th Assessment (CAA) Braden score (a too skin breakdown) wa at risk for skin break indicated R6's BIMS indicated R6 continu cognitive impairmen required extensive a staff, R6 did not wall mechanical lift) for tr extensive assist of o R6's physician's order	ated on the right hand which red to licensed staff, I factors, or interventions put healing and prevent further In 12/16/13, at 6:05 p.m. to ed, quarter-sized bruise I finger and thumb on the right rthotic device which covered 5 said he was not able to tell bruise happened. 26 a.m. R6 was observed with hotic on the right hand. The and was covered by the t hand orthotic. At the time of stated the bruised area um Data Set (MDS) dated R6's diagnoses included heart h, hyperlipidemia, aphasia, he right side. The Care Area dated 1/13/13; identified R6's I used to predict potential for s 17, which indicated R6 was down related to pressure.	F 3	09		

L

Event ID: 8EZ111

Facility ID: 00672

If continuation sheet Page 3 of 25

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/16/2014 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	JAN 2 0 2014	(X3) DAT	E SURVEY IPLETED
		245345	B. WING		MN Dept of Health <u>R</u> ochester	12/	/19/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CI 800 SECOND AVENL			
ST ISIDC	ORE HEALTH CENTER	OF GREENWOOD PRAIRIE		PLAINVIEW, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	the orthotic on at nig during the day. The meals and activities included medication which include Courr The plan of care dat apply the hand ortho- identified R6 also ha brace. The care plan around the orthotic lar redness or pressure On 12/18/13, at 10:4 (RN)-A, licensed pra DON were interview all verified they were confirmed there was (electronic form for a charting completed right hand. At the tim visually observed th between the thumb stated it did not look loosened the orthoti now. At 10:45 a.m. I at 3.5 centimeter (cr nursing assistants (for order was verified by they were not sure of assessed the orthoti the NA should have monitoring event for to monitor the bruise A nurses' note writte	included staff were to have ght for about six hours and on orthotic was to be off at . The physician 's orders also is that may cause bruising hadin and Aspirin daily. ted 1/18/13, directed staff to obtic twice daily. The care plan ad a foot brace and right arm in directed to observe the skin braces and during cares for e areas, including bruises. 41 a.m. registered nurse actical nurse (LPN)-C and red. RN-A, DON and LPN-C e not aware of the bruise and s no monitoring event charting skin issues) or other concerning the bruise on R6's me of the interview, RN-A e bruise on the right hand and the second finger and like an old bruise. RN-A c and R6 stated it felt better _PN-C measured the bruise m) x 3.0 cm and stated the NAs) applied the orthotic. The y LPN-C and RN-A stated of the last time therapy had ic. RN-A and LPN-C stated reported the bruise and a m should have been started a.	F 309				
	surveyor intervention	n by LPN-C and after n on 12/18/13, at 11:17 a.m. was noted on R6's right					

Facility ID: 00672

If continuation sheet Page 4 of 25

STATEMENT OF DEFICIENCIES AND FUNCTION       (20) PROVIDERSUPPLIERLA IDENTIFICATION NAMEER:       (20) MULTIFILE CONSTRUCTION A BUILING			AND HUMAN SERVICES				FORM	0: 01/16/2014 APPROVED 0: 0938-0391
NAME OF PROVIDER OR SUPPLIER     Z4343     Is integrated     12/19/2013       ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE     STREET ADDRESS, CITY, STATE, ZIP CODE 809 SECOND AXENUE NORTHWEST PLAINVEW, MN 55964     State, Zip CoDE       (X4,ID PRETX TAS     SUMMARY STATEMENT OF DEFICIENCIES IRCAN DEFICIENCY MUST BE PRECEDED BY FULL REQUIPERTORY OR LES (DENTHYME INFORMATION)     Ind PRETX TAG     IPROTECTION CORRECTION (RECH DEFICIENCY OR LES (DENTHYME INFORMATION))     D PRETX TAG     PRETX RECULATORY OR LES (DENTHYME INFORMATION)     000000000000000000000000000000000000				1		ple construction gJAN 2 0 2014		
IMME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, JP CODE       ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE     D0 05 9500A X0FUNE NORTHWEST PLAINVIEW, MN 55964       (X) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) REGULATORY OR LSC DEMTIFYING INFORMATION)     D PROVIDER SPLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     CM PREFIX REGULATORY OR LSC DEMTIFYING INFORMATION)     PROVIDER SPLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     CM PROVIDER SPLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     CM PREFIX PLAINTER     CM PLAINTE			245345	B. WING		MN Dept of Health Rephester	12	/19/2013
STISUME HEALING CANER OF GREENWOOD PRAINE       PLAINVIEW, MN 55964         (X4,ID)       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE REFECTED BY FILL REGULATORY OR LS DENTIFYING INFORMATION)       PBETX PAGE       PROVIDERS 740.00 CORRECTIVE ACTION (EACH DEFICIENCY)       COMPLETION (EACH DEFICIENCY)         F 309       Continued From page 4 hand, included the obtained measurements, identified RS was on Cournadin, had thin skin and the strap on the orthotic hand brace may have been "too tight." LPN-C indicated staff would be instructed to make sure the strap was loose. A nurses' note written by RN-A after surveyor intervention on 12/19/13, at 8:28 a.m. noted RG's right hand orthotic was checked. RN-A noted the NA stated it was like an old bruise.       F 309         On 12/19/13, at 8:35 a.m. DON stated she expected the NAs to report the bruise to the nurse. DON stated the nurse would also email the DON if the bruise was explainable or call the DON if it was not.       The facility's Monitoring and Investigation of incidents/accidents in the computerized medical record under "Events."       F 323         The facility's Accident/Incident-unexplained injuries policy dated 2/2003, directed all bruises, skin tears, scratches and other injuries that were not the result of a specific event were to be reported to the nursing supervisor as soon as the injury was noted. The policy directed the licensed nurse would then evaluate the injury an interview the resident if appropriate. Details of the injury were to be documented in the resident's medical record and the care plan updated.       F 323         F 323       HAZARDS/SUPERVISION/DEVICES       F 323	NAME OF	PROVIDER OR SUPPLIER						
PHID HEEK TAG     SUMMARY STATEMENT OF DEFICIENCIES (ECAN DEFICIENCY WIGT EF DEFICIENCIES RECOULATORY OR LSC IDENTIFYING INFORMATION)     D PETX TAG     PROVIDERS ADDATE CORRECTION (ECAN DEFICIENCY)     OCT CORRECTION (ECAN DEFICIENCY)       F 309     Continued From page 4 hand, included the obtained measurements, identified R6 was on Coumadin, had thin skin and the strap on the orthotic hand brace may have been 'too tight.'' LPN-C indicated staff would be instructed to make sure the strap was loose. A nurses' note written by RNA-After surveyor intervention on 12/19/13, at 8:28 a.m. noted R6's right hand orthotic was checked. RN-A noted the NA stated it was like an old bruise.     F 309       On 12/19/13, at 8:35 a.m. DON stated she expected the NAs to report the bruise to the nurses. DON stated the nurse would then open a monitoring event in the clinical record DON stated the nurse would also email the DON if the bruise was explainable or call the DON if it was not.       The facility's Monitoring and Investigation of Incidents/Accidents policy dated 12/2011, directed nursing staff to record all incidents/Accidents an intercember to be reported to the nurse would allo policy atted 22003, directed all bruises, skin tears, scratches and other injuries able or call is of the injury were to be documented in the resident fi merked the resident of apportiate. Details of the injury were to be documented in the resident merked nurse would then evaluate the injury and interview the resident fi apportiate. Details of the injury were to be documented in the resident's medical record and the care plan updated.     F 323       F 323     483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES     F 323	ST ISIDO	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE					
PREFIX TAG       CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION       PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       community and DEFICIENCY         F 309       Continued From page 4 hand, included the obtained measurements, identified R6 was on Couradin, had thin skin and the strap on the orthotic hand brace may have been "too tight". LPN-C indicated staff would be instructed to make sure the strap was loose. A nurses' nothe written by RNA after surveyor intervention on 12/19/13, at 8:28 a.m. noted R6's right hand orthotic was checked. RNA noted the NA stated it was like an old bruise.       F 309         On 12/19/13, at 8:35 a.m. DON stated she expected the NAs to report the bruise to the nurse. DON stated the nurse would also email the DON if the bruise was explainable or call the DON if it was not.       The facility's Monitoring and Investigation of Incidents/Accidents policy dated 12/2011, directed nursing supervisor as soon as the reported to the nursing supervisor as soon as the injuries policy dated 22/2003, directed all bruises, skin tears, scratches and other injuries that were not the result of a specific event were to be reported to the nursing supervisor as soon as the injury was noted. The policy dated the injury and interview the resident if appropriate. Details of the injury were to be documented in the resident's medical record and the called the three medical record and the called the three medical record and the called the filter medical record and the called the injury were to be documented in the resident's medical record and the called the filter medical record and the called the filter week as 483.25(h) FREE OF ACCIDENT S = 223       F 323	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				N	(275)
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Event ID: 8EZ111

Facility ID: 00672

If continuation sheet Page 5 of 25

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 01/16/2014 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245345	B. WING		MN Dept of Health Rochester 12	19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	
ST ISIDC	RE HEALTH CENTER	OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	environment remain as is possible; and	ge 5 is as free of accident hazards each resident receives on and assistance devices to	F 3	23	Please see attachment #2	1/28/2014
	by: Based on observat review, the facility fa (R28) was compreh use of side rails; fail Findings include: R2	NT is not met as evidenced ion, interview and document ailed to ensure 1 of 4 residents ensively assessed for safe led to identify . 28 was not comprehensively fe use of half (1/2) side rail on				
	10/27/13, identified impaired, required e for bed mobility, tran	imum Data (MDS) dated R28 was severely cognitively extensive assist of one staff nsferring and ambulation; R28 of side rails was not triggered				
	rail was observed of	4 p.m. a one half-length side n the right side of R28's low the bed was pushed next to				
	the low bed sleeping was up and the bed	D a.m. R28 was observed in g on her back. The side rail remained next to the wall. At ined in bed sleeping and the				
		sment for Restraint/Adaptive ls dated 7/23/13; identified				

Facility ID: 00672

If continuation sheet Page 6 of 25

# Attachment 2

# 483.25 (h)(1) Tag F323 Accidents and Supervision

Second Constants

St. Isidore Health Center of Greenwood Prairie staff ensure that the residents' environment remains safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues and implements procedures to prevent accidents and incidents.

The resident's use of and need for safety/enabling devices are assessed at admission and reassessed during the quarterly interdisciplinary care conferences and whenever there is a significant change in the resident's behavior, physical condition, and/or mental function. Side rails will only be used after a comprehensive assessment of the safety risks versus the benefits. The resident/family preference for side rail use will be taken into consideration during the assessment process. Education on the risks/ benefits will be provided to the family/resident as necessary.

The policies and procedures related to side rail use were reviewed and revised. An assessment of the appropriateness of side rails will continue to be done prior to use and a reassessment will be completed at least quarterly and with significant changes in condition. The safety of the side rail and the resident's ability to use the side rail to enable/improve independent bed mobility/transferring will be addressed in more detail. The resident's use of the side rail will be visualized as part of the assessment process. Side rail use will continue to be addressed in the resident's plan of care.

The policies and procedures related to investigation of the falls/incidents were reviewed and found appropriate. During the interdisciplinary team meetings Monday through Friday, the circumstances surrounding falls are reviewed, causal factors are investigated (need to toilet, pain, medication side effects, hunger/thirst, acute illnesses, etc.), the appropriateness and effectiveness of current safety interventions are reassessed, and the need for additional interventions is evaluated. The resident's care plan is modified as necessary to assure maximum safety and minimal risk of injury.

During the January 16, 2014 mandatory meetings, the licensed staff were instructed on 1) procedural changes including the need to address side rail safety/enablement during the assessment of the risks and benefits of assistive devices and 2) the need for comprehensive fall assessments which include a review of recent acute conditions that could be a contributing/causal factor of the fall.

During the January 23, 2013 mandatory meetings, the certified nursing assistants were instructed to be observant/cognizant of and report health changes and environmental factors that may increase of the risk of resident falls/injuries. The nursing assistants will also be instructed to be aware of and report any changes regarding the resident's use of rails to facilitate independent bed mobility/transferring.

**Resident number 28** - The risks/benefits and safety of side rail use was comprehensively reassessed by a registered nurse. The resident was visualized using the rail to facilitate independent repositioning in bed and transferring from bed to chair. Since the resident does not exhibit behaviors or movement disorders that increase the risk of injury from rail use, use of assistive side rails on the side of the bed that is not against the wall will continue. The care plan has been reviewed and updated accordingly. Since the side rail does not meet the definition of a physical restraint, side rail use is appropriately not coded on the minimum data set (MDS).

**Resident number 36** – The interdisciplinary team reinvestigated the resident's recent falls and the probability of recurring urinary tract infections being a contributing factor. The plan of care has been updated to include close monitoring of urinary symptoms and subsequent safety precautions. The direct care staff has been informed of the increased safety risks related to urinary tract infections and instructed to immediately report changes in bladder function/urinary-related symptoms to the charge nurse.

The safety/mobility risks and benefits of side rail use for current residents will be reassessed at the next care conference or sooner if there is a change in the resident's condition or circumstance that may impact the risks/benefits of rail use. The Clinical Manager/designee will monitor compliance by conducting random chart audits for the next four weeks to assure comprehensive assessments of the safety of side rail use and the investigation of acute conditions as a causal factor for falls. The results of the audits will be reviewed during the January Quality Council meeting and ongoing.

Completion date: January 28, 2014

		AND HUMAN SERVICES				FOR	C. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) D	ATE SURVEY OMPLETED
		245345	B. WING		MN Dept of Health Rochester	1	2/19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDO	ORE HEALTH CENTER	OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	R28 would use the f medical symptom for weakness and indic rail was to assist R2 mobility. The form in were explained to R 7/28/13. The assess safety and it did not approaches attempt Note dated 10/27/13 use 2 upper half sid repositioning]." On 12/18/13, at 9:57 (DON) and registered interviewed regardin indicated R28 had n and indicated every resident safety, wha appropriateness of t On 12/19/13, at 7:50 regarding R28 's sid stated staff goes in a bed boundaries, or t assessment in the c safety and stated sat to the side rail asses quarterly reviews we was a change in the verified nothing else regards the safe use Facility policy for Sid indicated side rails w restraints and side ra assessed for proper directed, "Safety of t	top two half side rails. The for use of the side rails was rated the reason for the side 8 with transferring and bed ndicated the risks and benefits 28 and their family on sment did not address R28's include the alternative ted. A Quarterly Progress 3, indicated R28 "continues to e rails for T&R [turning and 7 a.m. the director of nursing ed nurse (RN)-A were ng R28's use of side rail. Both to incidents with the side rail side rail was reviewed for t they were used for and the	F 3	23	3		

Facility ID: 00672

If continuation sheet Page 7 of 25

CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938-039         STATEMENT OF DEFICIENCIES       (11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE 800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964         ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE         PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       Continued From page 7       (S0) COMPLETION DEFICIENCY)         F 323         Continued From page 7 are in place." The procedure indicated nursing staff was expected to consider all alternative safety methods and care approaches before physical restraint was utilized, such as, but not limited to bolster pillows, floor bed mats, personal bed alarms, scheduled snacks and toileiting, and adequate daily exercise. R36 recurrent urinary tract infections (UTIs) were not identified as potential risk factor for falls.       F 323         R36's Current ICD-9 Diagnoses dated as printed 12/18/13 included chronic kidney disease with a history of urinary tract infections (UTI) and falls.       History of urinary tract infections (UTI)	DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       IDENTIFICATION NUMBER:       A. BUILDING       IDENTIFICATION NUMBER:       IDENTIFICATION       IDENTIFICATION NUMBER:       IDENTIFICATION       IDENTIFICATIO	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	T		0		
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     CMPLETION DATE       F 323     Continued From page 7 are in place." The procedure indicated nursing staff was expected to consider all alternative safety methods and care approaches before physical restraint was utilized, such as, but not limited to bolster pillows, floor bed mats, personal bed alarms, scheduled snacks and toileting, and adequate daily exercise. R36 recurrent urinary tract infections (UTIs) were not identified as potential risk factor for falls.     F 323       R36's Current ICD-9 Diagnoses dated as printed 12/18/13 included chronic kidney disease with a     R30's Current ICD-9 Diagnoses dated as printed								
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PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Compréficience DATE         F 323       Continued From page 7 are in place." The procedure indicated nursing staff was expected to consider all alternative safety methods and care approaches before physical restraint was utilized, such as, but not limited to bolster pillows, floor bed mats, personal bed alarms, scheduled snacks and toileting, and adequate daily exercise. R36 recurrent urinary tract infections (UTIs) were not identified as potential risk factor for falls.       F 323         R36'S Current ICD-9 Diagnoses dated as printed 12/18/13 included chronic kidney disease with a       R36's Current ICD-9 Diagnoses dated as printed	ST ISIDC	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE					
are in place." The procedure indicated nursing staff was expected to consider all alternative safety methods and care approaches before physical restraint was utilized, such as, but not limited to bolster pillows, floor bed mats, personal bed alarms, scheduled snacks and toileting, and adequate daily exercise. R36 recurrent urinary tract infections (UTIs) were not identified as potential risk factor for falls. R36's Current ICD-9 Diagnoses dated as printed 12/18/13 included chronic kidney disease with a	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Review of incident report documentation from 8/05/13, to 12/16/13, revealed R36 experienced falls on 8/5/13, 11/9/13, 11/24/13, 11/29/13, and 12/13/13. Of the five falls, three identified R36 had been treated for a UTI, and one identified R36 had been monitored for UTI symptoms. The facility's "Fall Risk (Acuity)" assessment form dated 9/23/12 indicated R36 had a history of falls with risk factors that included incontinence. The assessment identified R36 as being at high risk for falls related to confusion and not always aware of safety. The annual Minimum Data Set (MDS) dated 9/27/13, indicated R36 had a Brief Interview for Mental Status (BIMS, a tool used to determine cognitive loss) score of three out of 15, which indicated severe cognitive impairment. The MDS further indicated R36 required extensive assist of one staff for transfers and toileting, was frequently incontinent of urine and was not on a toileting program to manage urinary incontinence. The MDS identified R36 had experienced one fall with no injury since admission. The Care Area Assessment (CAA) identified R36 had been		are in place." The p staff was expected safety methods and physical restraint wa limited to bolster pill bed alarms, schedu adequate daily exer R36 recurrent urinar not identified as pot R36's Current ICD-9 12/18/13 included ch history of urinary tra Review of incident r 8/05/13, to 12/16/13 falls on 8/5/13, 11/9/ 12/13/13. Of the five had been treated for R36 had been monit The facility's "Fall Ri dated 9/23/12 indicat with risk factors that assessment identifie for falls related to co aware of safety. The annual Minimum 9/27/13, indicated R Mental Status (BIMS cognitive loss) score indicated severe cog further indicated R36 one staff for transfer frequently incontiner toileting program to r The MDS identified F with no injury since a	rocedure indicated nursing to consider all alternative I care approaches before as utilized, such as, but not lows, floor bed mats, personal iled snacks and toileting, and rcise. ry tract infections (UTIs) were ential risk factor for falls. Diagnoses dated as printed hronic kidney disease with a act infections (UTI) and falls. eport documentation from 6, revealed R36 experienced /13, 11/24/13, 11/29/13, and e falls, three identified R36 r a UTI, and one identified tored for UTI symptoms. isk (Acuity)" assessment form ated R36 had a history of falls included incontinence. The ed R36 as being at high risk onfusion and not always an Data Set (MDS) dated 36 had a Brief Interview for 5, a tool used to determine e of three out of 15, which gnitive impairment. The MDS 6 required extensive assist of s and toileting, was at of urine and was not on a manage urinary incontinence. R36 had experienced one fall admission. The Care Area	F 3	23			

If continuation sheet Page 8 of 25

		AND HUMAN SERVICES					FORM	): 01/16/2014 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				<u> </u>	(X3) DA	). 0938-0391 TE SURVEY MPLETED
		245345	B. WING		MIN E	)ept of Health lochester		/19/2013
NAME OF	PROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE	E, ZIP CODE	1 12	113/2013
		OF GREENWOOD PRAIRIE			00 SECOND AVENUE NORT			
		OF GREENWOOD PRAIRIE		F	PLAINVIEW, MN 55964			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD	BE	(X5) COMPLETION DATE
F 323	Continued From no.	~~ <sup>0</sup>						
1 525		-	F 3	323				
	toilet.	o urinate and took self to the						
	being at high risk for include interventions falls which included	I 10/2/13, identified R36 as r falls however, did not s based on history of previous R36 had UTIs at the time te to the falls and to prevent sible injuries.						
	precautions to includ interventions for UTI care plan. RN-A veri	3 a.m. RN-A reported the fall de monitoring and Is were to be included on the fied R36's chronic UTIs had sed in relation to R36 ' s fall						
	fall risk documentation chronic UTIs. DON v for and/or monitored	a.m. the DON verified the on should have included verified R36 had been treated for UTI symptoms which four of the last five falls.						
F 329	dated 7/2013, identif responsible for review factors and initiating	Accidents/Incidents policy ied the charge nurse was wing occurrences for risk appropriate interventions. GIMEN IS FREE FROM UGS	F 32	29	Please see att	achment #3		1/28/2014
	unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mo indications for its use adverse consequenc	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any			·			

Facility ID: 00672

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# Attachment 3

#### 483.25(I) Tag F329 Unnecessary Drugs

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St. Isidore Health Center of Greenwood Prairie staff ensures that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued.

St. Isidore Health Center of Greenwood Prairie staff ensures that 1) residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record and 2) residents who use antipsychotic drugs receive gradual dose reductions with attempts to manage behaviors using nonpharmacological interventions. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible.

The policies and procedures related to the administration of psychotropic medications were reviewed and found appropriate. Except in the event of resident behaviors that place them or others at high risk of injury/life threatening circumstances, initiation of PRN antipsychotic orders will be authorized by the Clinical Manager or Director of Nursing.

Use of the daily *Behavior Flowsheet* will continue. This tool is completed by the direct care staff and identifies target behaviors and tracks the frequency and the effectiveness of related medications for residents who receive antipsychotic and/or antianxiety medications.

Guidelines/parameters are developed when psychotropic medications are prescribed on an as needed (PRN) basis. At the time of the quarterly care conference and more often if needed, the resident's medications are reassessed by licensed nurses and the social worker. The medication type/dose and other related information are reviewed to assure that the record continues to reflect adequate indications for use, the consideration of dose reductions, and nonpharmacological interventions as appropriate. Psychotropic medication will continue to be reviewed monthly by the consultant pharmacist and during the routine 30/60 day visits by the attending physician/nurse practitioner. During the January 16, 2014 mandatory meetings, the licensed nurses were instructed on behavior related policies and procedures including 1) the need to document the resident's target behaviors, nonpharmacological interventions, and the response to pharmacological and nonpharmacological interventions and 2) the need to follow the care plan and update the plan as needed.

During the January 23, 2014 mandatory meetings, the certified nursing assistants were instructed 1) to be observant for behaviors 2) to consistently use the *Behavior Flowsheet* to record the frequency of target behaviors, the interventions attempted to modify the behavior, and the effectiveness of the intervention and 3) on the necessity to report behaviors to the nurse.

**Resident number 22** – The 101-year-old resident was admitted November 1, 2007 with a diagnosis of depression with an order for an antidepressant. On December 19, 2013, the progress notes from her attending physician state, "Patient has been on antidepressant medication, maintained her serotonin level for a number of years on Zoloft 50 mg daily . . . because of the current regulation, even though I feel this is totally wrong, will decrease her down to 25 mg and watch closely, because of her excellent cognitive status, for any changes. If patient does have any problem, will immediately take her back to the Zoloft 50 mg status . . . Approximately 30 minutes used with her on discussing the medication, discussing how the medicine works, discussing the patient's symptomatology. She is very hesitant to decrease but again was told we will watch closely. If patient can get by with 25 mg, this is excellent, but again, I am very hesitant to make changes as she is doing so well at 50 mg. Feeling adjusting the medicine with no side effects of concerns, just simply due to state regulation and not to symptomatology of the patient is not appropriate."

Two weeks after the dose reduction, the resident started to complain of insomnia with recurrent tearfulness and distressing thoughts related to past family issues. Subsequently, the physician increased the Zoloft back to 50 mg daily with Ativan .5 mg every night for thirty days to decrease the resident's anxiety until the maximum therapeutic effect of the increased Zoloft dose is reached. The resident's plan of care was reviewed and updated by the interdisciplinary team January 8, 2014. The resident's mood will continue to be monitored and the physician notified of changes if necessary.

**Resident number 3** – The 90-year-old resident was admitted to the facility February 22, 2013. The July 18, 2013 notes from the psychiatric clinical nurse specialist indicate a chief compliant of "episodes of anxiety and fearfulness. Some reported visual hallucinations. She has not been eating right; poor appetite." According to the notes, the

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resident stated, "What is that cat doing in here?" when no cat was present. Resident also asked the clinician, "Do you see that wine that is floating through the air? It kind of bends and twists in the air." The clinician further notes, "has had some outbursts of anxiety; demanding that staff leave the room . . . appears to be having more episodes of confusion . . . did appear anxious and had some difficulty engaging in conversation. She had a difficult time making eye contact. Seroquel 12.5 mg was increased from once per day to BID per Psychiatry recommendations."

The July 18, 2013 attending physician's note states, "Patient is quite confused today with flight of ideas, very agitated, patient at first wanted to leave the nursing home was redirected, sitting in a chair, felt that people around were talking about her, wanted to know what I wanted . . . I feel that this is a definite significant paranoia with her dementia, but also question a psychotic episode with this patient . . . Will increase patient's Seroquel for now to try and make patient more comfortable . . . Going through nursing records, patient has been quite agitated, it is very obvious that the Seroquel we have run at this low-dose is not causing any problems with sedation, and so will make a significant jump to see if this helps out with patient's paranoia and confusion." Another psychiatric consult was recommended.

The September 19, 2013 physician's note states, "Patient is quite anxious . . . will continue the Seroquel for her anxiety . . . Feel it would be wise to consider an increase on same as patient is definitely having a significant paranoia and agitation today. Will take the Seroquel up to 75 mg at bedtime. Will also add in a 50 mg every a.m. Will ask that the patient be given that now."

The November 20, 2013 attending physician's progress note states, "Most significant for anxious depression with features of psychoses and hallucinations. Hallucinations have responded nicely to dose adjustment of her sertraline and Seroquel, but it would be inappropriate to try dose reduction trials at this point, since symptoms have only been controlled for approximately 2 months. Since her September psychiatric medication changes and discontinuation of cardioactive medicines, the PRN Seroquel appears to have been rarely used . . . No dose reduction trials seem warranted. Medications are continued without an intended strategy change."

On December 20, 2013, the PRN Seroquel was discontinued. On January 13, 2014, the attending physician ordered routine Ativan 0.25 mg BID for increased anxiety exhibited by yelling, striking out, refusing cares, and attempting to leave the building.

The resident's target behaviors will continue to be monitored on a daily basis and reviewed periodically by a licensed nurse and quarterly by the interdisciplinary care team.

Any significant changes will be reported to the physician. The care plan was reviewed and updated.

Compliance with tracking target behaviors and monitoring effectiveness of interventions will be will monitored by the Director of Nursing and Clinical Manager by random record reviews for the month. If noncompliance is noted, additional tracking and staff training will be done. The Director of Nursing and Consultant Pharmacist will monitor the physician's justification for not tapering medications to assure regulatory compliance. Physician education will be done as necessary. The results of the audits will be reviewed during the January Quality Council meeting and ongoing.

Completion Date: January 28, 2014

		AND HUMAN SERVICES				FORM	: 01/16/2014 APPROVED : 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION JAN 2012 2014	(X3) DAT	TE SURVEY MPLETED
		245345	B. WING _		Rochester	12	/19/2013
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDO	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE			00 SECOND AVENUE NORTHWEST LAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and d record; and residen drugs receive gradu behavioral intervent contraindicated, in a drugs. This REQUIREMEN by: Surveyor: Lageson, Based on observatio review, the facility fa psychotropic medica justification as to wh	reasons above. hensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug y to treat a specific condition ocumented in the clinical ts who use antipsychotic ial dose reductions, and ions, unless clinically an effort to discontinue these	F 32	29	DEFICIENCY)		
	(R22) reviewed for u and the facility failed use of an as needed 1 of 5 residents (R22 unnecessary medica Findings include: R2 did not have a reduc A review of R22's ca indicated R22's diag insomnia, depressive heart failure. The ca has alterations in mo	Innecessary medication use I to identify parameters for I antipsychotic medication for 2, R3) reviewed for	·				

Event ID: 8EZ111

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		םוד ו	LE CONSTRUCTION		E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					APLETED
			A. BUILL	JING			
		245345	B. WING	i	MOLDept of Health	12	/19/2013
NAME OF I	PROVIDER OR SUPPLIER		L.,	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
					800 SECOND AVENUE NORTHWEST		
ST ISIDC	RE HEALTH CENTER	R OF GREENWOOD PRAIRIE	i		PLAINVIEW, MN 55964		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
TAG	REGULATORT OR E		TAG		DEFICIENCY)		
<b>—</b>							
F 329	Continued From pa	ge 10	F:	329			
	included monitor ac	lverse side effects, administer					
	Zoloft as ordered, fa						
	11/2008-returned to	50 mg dose and failed. Dose					
	increased to 75 mg	daily 1/27/2011-effective					
	dose."						
		mentation in progress notes					
		nitoring from 3/25/13, through					
		to have minimal depression					
		IQ9 score, and was social with					
	no mood behaviors						
		macist's recommendation to					
		11/26/13, indicated R22's					
		ant) was decreased from 75					
		50 mg in 12/20/12, was					
		e identified R22 required an					
		for another possible gradual					
		R) attempt at that time. The					
		regarding the GDR was dated					
		Considered with RN					
		nd patient [R22] in November.					
		2014." The clinical record					
	lacked evidence a c						
		GDR of the antidepressant					
	was contraindicated						
		00 a.m. the director of nursing					
		ed nurse (RN)-A were ng R22's lack of a gradual					
	5	0					
		R) in Zoloft (antidepressant) 2/12. RN-A stated the GDR					
		because of mood changes					
		's tendency to get moody and					
	•	fferent times of year. RN-A					
		eping problems relating to a					
		resident did not want a dose					
		physician made a note of it on					
		irther stated R22 also had a					
		ble of months ago. RN-A					
		on was not documented					
		ued use and effectiveness of					

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		AND HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		245345	B. WING		MN Dept of Health	12	/19/2013
NAME OF	PROVIDER OR SUPPLIER	<b>1</b>		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STISIDO	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE			00 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	physician's order da decrease to 25 mg (This occurred after regarding lack of Gl agreed the clinical j pharmacy recommends not specific enough she knew about R2 documented (sease family, and room ch antidepressant use. R3 did not have pa necessary) antipsyce and did not have de target behaviors or interventions for sch R3's Physician Orde indicated R3 had dia symptom hallucinati and depressive disc The quarterly MDS continued to have si delusions, physical 1 toward others 1 - 3 of symptoms directed other behavioral sym others 4-6 days with but less than every of On 12/19/13, at 7:32 in her wheelchair in within reach. Her ey R3 began mumbling room at 7:44 a.m. to	00 a.m. RN-A provided a ated 12/19/13, that showed a in the R22's Zoloft medication. r surveyor discussion DR and justification). RN-An ustification identified on the endation dated 11/26/13, was r RN-A also stated any issues 2 should have been onal mood swings, issues with hange) in relation to the rrameters for use of a prn (as chotic medication (Seroquel) eveloped individual specific individualized behavioral neduled Seroquel. er Report dated 12/18/13 agnoses to include dementia, ions, anxiety state, debility, order. on 11/24/13 indicated R3 evere cognitive loss; R3 had behavioral symptoms directed days, verbal behavioral toward others 4-6 days and mptoms not directed toward in rejection of care 4-6 days,	F3	329			

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	01/16/2014 APPROVED 0.0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
		245345	B. WING		· · · · · · · · · · · · · · · · · · ·	i Həsifin	12	/19/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI			
ST ISIDO	ORE HEALTH CENTER	OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHW PLAINVIEW, MN 55964	EST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	COMPLETION DATE
F 329	minutes after nurse On 12/19/13, at 7:49 usually more anxiou morning anxiety had couple of weeks. RN R3 the scheduled S R3 would be calmer to start yelling "help thought R3 may be bathroom. R3 was t and then taken to th observed to sit quiet The care plan dated received antidepress depression diagnosi impact R3. The goal medication will resul resident's functional participating with he complaints of discor- included to administ observe effects of Zo plan directed to atter intervention such as food, change in posi plan directed to mon to medication, include RN review, provide of resident/family and a arise. A hand written	left. 9 a.m. RN-B stated R3 was is in the evenings and her d increased over the last N-B stated she had just given eroquel and stated in an hour At 7:55 a.m. R3 was heard me" louder. RN-B stated she needed to go to the hen taken to the bathroom e dining room where she was thy at the table. 12/02/13 indicated R3 sant medication related to s and chronic pain may was that R3's use of t in improvement in the status as evidenced by: r ADL's and decreased nfort. The interventions er medication as ordered and oloft and Seroquel. The care mpt non-pharmacological : music, visiting with others, tion, and toilet use. The care itor R3's mood and response le consultant pharmacy and educational material to answer questions as they statement dated 4/24/13,	F 3	329				
	diagnosis of hallucin The care plan identif Physician ' s orders i Seroquel 12.5 milligr	the care plan, identified R3's ations/paranoid/delusional. ied R3 used Seroquel. ndicated on 4/24/13, to offer ams (mg) every day at creased on 5/28/13. On						

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		AND HUMAN SERVICES				FORM	D: 01/16/201 MAPPROVE	D
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	D. 0938-039 TE SURVEY MPLETED	1
		245345			NIN Dept of Health	1:	2/19/2013	
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			-
		R OF GREENWOOD PRAIRIE		8	300 SECOND AVENUE NORTHWEST			
		OF GREENWOOD PRAIRIE		F	PLAINVIEW, MN 55964			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	-
E 220	O section of E							
F 329		-	F 3	29				
		ā mg was ordered prn (as						
	needed) every six h							
	addition R3 was off	ioia/agitation/delirium; in ered scheduled Seroquel 75						
	mg at bedtime and	50 mg every morning. R3 also						
	was offered Zoloft (a	an antidepressant) 125 mg						
	every morning.							
		ed prn Seroquel 25 mg on the						
	following dates:							
	- On 9/26/13, at 3:18	5 p.m. for agitated behavior. A						
	indicated R3 was ca	e same date and time Iling out and swinging at						
	invisible things and	was unable to be redirected						
	with orientation to su	urroundings. No						
	non-pharmacologica	I charting was noted on other						
	interventions used p	rior to giving the prn						
	Seroquel. There was	s no documentation on the						
	effectiveness of the	prn medication.						
	- On 9/28/13, at 3:44	a.m. for agitated and						
-	regarding use of non	o documentation was noted						
	interventions tried be	efore giving the prn Seroquel						
	or the effects of the p	orn given.						
	- On 10/17/13, at 11:	57 p.m. for restlessness and						
	hollering out. There v	was no documentation						ĺ
	regarding symptoms	displayed or						
	non-pharmacological	interventions used prior to						ĺ
	prn given.	uel or the effectiveness of the				ļ		
		2 a.m. for hallucinations,			· · ·			
	agitation. A nurse's n	ote for the same date and						
1	time indicated R3 ref	used medications in the						
1	morning and refused	to eat breakfast. Staff						
(	documented they we	re able to get R3 to take her						
5	scheduled Seroquel a	and the prn dose. The note						
i	ndicated R3's agitation	on improved, but was						
1	peginning to get wors	e again. No documentation						
r	egarding symptoms	displayed or						

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DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES					MAPPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	•				D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		ATE SURVEY
			A. BUILD	ING	<u></u> };`` ``; : : : : : : : : : : : : : : : : : :	ò.	
		245345	B. WING			1:	2/19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDC	RE HEALTH CENTER	OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
	prn dose were note - On 11/10/13, at 3: documentation rega non-pharmacologica prn dose and no effi documented. - On 11/24/13, at 12 documentation rega non-pharmacologica prn dose. A nurses p.m. indicated R3's lunch and she reque Seroquel for agitatic Documentation on ti indicated at 10:30 p effective. - On 11/29/13, at 12 a.m. dose and incre dated 11/29/13, at 3: the morning medica Seroquel at 12:00 m non-pharmacologica documented. - On 12/07/13, at 1:3 No documentation m or non-pharmacologica to prn dose were do The Behavior Flow S for October, Novemil The nursing assistar many times R3 was were no specific targ behavioral symptom Non-pharmacologica	al interventions used prior to d. D6 p.m. for agitation. No inding symptoms displayed or al interventions used prior to ectiveness of the prn were 1:11 p.m. for anxiety. No inding symptoms displayed or al interventions used prior to notes dated 11/24/13 at 3:18 daughter was at facility for ested R3 to have a prn on and anxiety. he prn medication form .m. the prn dose was not 1:19 p.m. given for refusal of ased anxiety. A nurse's notes 27 p.m. indicated R3 refused tions, but agreed to prn bon which was effective. No al interventions were B1 a.m. for increased anxiety. egarding symptoms displayed ical interventions used prior cumented. Sheets for R3 were reviewed ber, and December, 2013. Ints were to document how bited anxiety: onal behaviors and how agitated/paranoid. There get behaviors or targeted	F3	29			

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CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0930         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUR COMPLETE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	
245345 B. WING 12/19/20	9/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 SECOND AVENUE NORTHWEST	
ST ISIDORE HEALTH CENTER OF GREENWOOD PRAIRIE PLAINVIEW, MN 55964	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE
<ul> <li>F 329</li> <li>Continued From page 15</li> <li>R3 what it was she needed. These did not match up with the care plan interventions of music, visiting with others, food, change in position, and toilet use.</li> <li>Review of the psychotropic review dated 6/10/13, at 10:32 a.m. indicated R3's Seroquel was increased to 12.5 mg twice a day on 5/28/13 and noted R3's behaviors had increased. No documentation related to behavioral symptoms or effectiveness of non-pharmacological interventions was noted.</li> <li>Review of the facility's psychotropic review dated 9/04/13, noted a review of R3's medications, with increases of Seroque Inted. Quantitative charting was noted. Although the review indicated more interventions were added to the effectiveness of non-pharmacological interventions was noted. Although the review indicated more interventions were added to the effectiveness of non-pharmacological interventions was noted. Although the review indicated more interventions were added to the care plan.</li> <li>Review of the psychotropic review dated 11/15/13, at 10:29 a.m. indicated R3 was moved to a room where R3 would have a roommate. The review indicated these behaviors were somewhat less and were managed by staff. The review indicated R3 received Seroquel 75 mg every day and had a pm 25 mg dose that has been used once in the last two weeks. The review indicated R3 received Seroquel 75 mg every day and had a pm 25 mg dose that has been used once in the last two weeks. The review indicated R3 had psychotic episodes of paranoia with confusion, agitation, hallucinations and R3 was moved in the offectiveness of R3 mag theory and R3 was delusional R3 was delusional R3 was delusional R3 was delusional R3 was moved to a norw where R3 mould be and ro R3 was moved in the offectiveness R4 may the review indicated R3 neeview Seroquel 75 mg every day and had a pm 25 mg dose that has been used once in the last two weeks. The review indicated R3 had psychotic episodes of paranoia with confusion, agitation, hallucinations</li></ul>	

Facility ID: 00672

If continuation sheet Page 16 of 25

		AND HUMAN SERVICES				FORM	): 01/16/2014 1 APPROVED ): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		TE SURVEY MPLETED
		245345	B. WING	;	Contraction (1974)	12	/19/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDC	RE HEALTH CENTER	R OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Continued From pa	-	F	329	9		
	of non-pharmacolo	gical interventions was noted.					
	charted on behavio least quarterly in th	0 a.m. RN-A stated she rs/psychotropic medications at e chart. RN-A indicated staff tween times if there were any					
	parameters for R3 hallucinations, para stated staff was to first and if R3 was in Seroquel could be nurses were aware interventions and the located on the care	8 a.m. DON stated the to receive prn Seroquel were anoia, and agitation. DON try non-pharmacological things not re-directable, then the prn offered. DON stated the of the non-pharmacological he interventions would be plan. DON verified no prn Seroquel was on R3's					
F 431 SS=E	Management policy order to optimize the medication therapy potential adverse c attending physician pharmacist perform appropriate, effective As needed (PRN) of monitored for the e or possible adverse 483.60(b), (d), (e) I LABEL/STORE DR	DRUG RECORDS, UGS & BIOLOGICALS	F 4	431	<sup>1</sup> Please see attachment #	ł4	1/28/2014
	a licensed pharmad of records of receip	nploy or obtain the services of cist who establishes a system ot and disposition of all sufficient detail to enable an					

Facility ID: 00672

If continuation sheet Page 17 of 25

# Attachment 4

## Regulation 483.60(b, d, e) F431 Labeling of Drugs and Biologicals

St. Isidore Health Center of Greenwood Prairie provides pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. A licensed pharmacist collaborates with facility staff to coordinate pharmaceutical services within the facility and to guide development and implementation of related procedures. The facility utilizes only persons authorized under state requirements to administer medications.

In accordance with State and federal law, the facility policy requires that drugs and biologicals are stored in a secure, locked location at the proper temperature with access only by authorized personnel.

The procedure for monitoring refrigerator temperatures was reviewed and found appropriate. A new refrigerator has been purchased for the storage of medications at the nurses' station. The staff will continue to record the refrigerator temperatures on a routine basis. Adjustments will be made if temperatures are outside the 36-46 degrees Fahrenheit range. The inability to maintain acceptable temperatures will be reported to the maintenance department for follow up.

To monitor compliance, the Director of Nurses will audit the refrigerator temperature logs for one month. Any deviation from the acceptable range will be investigated and corrective action taken.

Completion Date: January 28, 2014

		AND HUMAN SERVICES					FORM	APPROVED
· ·	CONTRACTOR OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPI	E CONSTRUCTION	<u> </u>		. 0938-0391 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				- アビモニア 近日		IPLETED
		245345	B. WING			MN Dept of Health Rochecter	12	/19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CIT	TY, STATE, ZIP CODE	•	
ST ISIDC	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE			00 SECOND AVENU PLAINVIEW, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORR	S PLAN OF CORRECTIO ECTIVE ACTION SHOULD ENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	records are in order	ge 17 ion; and determines that drug · and that an account of all naintained and periodically	F 4:	31				
	labeled in accordan professional principl appropriate accesso							
	facility must store al locked compartment	State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to keys.						
	permanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib	ovide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the nimal and a missing dose can						
	by: Based on observation review, the facility fa maintain the medicar identified range of 36 This had the potentiar	T is not met as evidenced on, interview and document iled to implement a system to tion refrigerator within 5-40 degrees Fahrenheit (°F). al to affect all residents who efrigerated medication/s.				,		

Facility ID: 00672

If continuation sheet Page 18 of 25

		AND HUMAN SERVICES				FORM	D: 01/16/2014 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		245345	B. WING		MN Dept of Health Supposer	12	/19/2013
NAME OF	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	14	15/2015
ST ISIDO	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE			00 SECOND AVENUE NORTHWEST LAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>K</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Findings include: On 12/19/13 at 10:5 refrigerator in the nu This was verified by (LPN)-D. LPN-D ver Center temperature refrigerator #3 indic; range should have to The refrigerator tem 10/16/13 - 10/31/13, 24-28 °F. The refrige 11/01/13 -11/20/13 in ranged from 28-30 ° were three days the recorded and on 11/ 32 °F. From 12/7/13	53 a.m. noted medication urse 's station to be at 36 °F. r licensed practical nurse rified the St. Isidore Health record of medication room ated the normal refrigerator been 36-40 °F. perature log for the dates of indicated temperatures from erator temperature log from ndicated the temperature F. On 11/28 - 11/31, there temperatures were not 29, the temperature was at - 12/19/13, the #3	F 43	31			
	On 12/19/13, at 10:5 refrigerator temperat staff. On 12/19/13, at 12:4 during the observatio were observed in ref suppositories, biscola solution, Pneumovac should be refrigerato 36-46 °F). intraveno Insulin (label states k freezing), Levemir (la Influenza vaccine (lal (keep in cold place, a vial, Bisocodyl, Ativar	emperatures from 32 - 34 °F. 33 a.m. LPN-D stated the tures were logged in by night 0 p.m. with LPN-D present on, the following medications rigerator #3: Tylenol ax, Bronovana inhalation c (which the label indicated r with temperatures between us C-Ceftriazone, Novolog teep in cold place, avoid abel stating 36-45 °F), bel states 36-46 °F), Novolin avoid freezing), Tuberculin n Liquids (label to be stored nd lorazepam injectables D verified the above					

		AND HUMAN SERVICES				FORM	): 01/16/2014 1 APPROVED ). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUC	end and badde		TE SURVEY MPLETED
		245345	B. WING		MM Dept of Health Rochastor	12	/19/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRI	ESS, CITY, STATE, ZIP CODE		
ST ISIDO	DRE HEALTH CENTER	OF GREENWOOD PRAIRIE		800 SECOND PLAINVIEW,	AVENUE NORTHWEST MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	OVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHOU -REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431		-	F4	31			
	(RN)-A and the med (MRC)-F were inter not aware of the low #3 and she was not been contacted. MI medications had be 11/31/13, because of had been replaced thad not been contact low temperatures. E the staff should hav the refrigerator if it w stated staff needed	18 a.m. the registered nurse dical records coordinator viewed. RN-A stated she was v temperature in refrigerator aware if the pharmacy had RC-F stated some en thrown out around of freezing and the refrigerator twice. MRC-F verified they cted regarding the continued Both RN-A and MRC-F stated e adjusted the temperature of vas too high or too low. Both to report the continued low her MRC-F or maintenance					
1	he was not aware or medication refrigera On 12/19/13, at 12:4 procedure for refriger requested, but none 483.70(h) SAFE/FUNCTIONAL E ENVIRON The facility must pro	40 p.m. a policy and erator temperatures was was provided. L/SANITARY/COMFORTABL wide a safe, functional, rtable environment for	F 4	<sup>55</sup> Ple	ase see attachment #	5	1/28/2014
	by: Based on observation review, the facility fa	T is not met as evidenced on, interview and document iled to maintain resident care					
ORM CMS-25	67(02-99) Previous Versions (	Obsolete Event ID: 8EZ111		Facility ID: 00672	If continu	ation sheet	Page 20 of 25

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## Attachment 5

## Regulation 483.70(h) Tag F465 Safe, Sanitary, Comfortable Environment

It is the policy of St. Isidore Health Center of Greenwood Prairie to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

As part of an ongoing process to provide a pleasant, home-like environment, St. Isidore Health Center of Greenwood Prairie has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff.

A maintenance check list will continue to be used for inspection of resident rooms at the time of discharge and at least yearly. The condition of the walls, ceilings, radiators, and doors will be checked; damaged equipment and furnishings will be repaired/replaced as needed. All wheelchairs/scooters have been inspected to assure intact, cleanable surfaces. Inspection of the condition of the wheelchair/scooter seat, back and arm vinyl will be done during the routine cleaning of the wheelchair/scooter.

The repair of the vinyl on the wheelchair/scooter and the repair of the ceiling tiles, wall beams, radiators, and door surfaces are in process with planned completion by January 28, 2014.

During the January 16 and 23, 2014 mandatory meetings, all staff was reminded to observe for resident equipment/furnishings/structures that need to be repaired or replaced. The procedures for reporting work items to the Director of Maintenance were reviewed.

Compliance will be monitored by the administrator through direct observation and review of the maintenance checklists.

Completion date: January 28, 2014

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(	<u> MB NO</u>	. 0938-0391
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG	13.00		NFLETED
		245345	B. WING		John Brand	12	140/2042
NAME OF	PROVIDER OR SUPPLIER		<u>-</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		19/2013
					00 SECOND AVENUE NORTHWEST		
STISIDO	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE		Ρ	LAINVIEW, MN 55964		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	JE NORTHWEST 55964 R'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE COMPLETION	
		,					
F 465	Continued From pa	•	F 46	65			
		ry/good repair for 2 of 2					
		2); failed to maintain physical d repair for 8 of 24 resident					
		R36, R19, R3, R1, R33, R32)					
	reviewed.	,					
	Findings Indudes						
	Findings Include:						
	ELECTRIC SCOOT	ER AND WHEELCHAIR					
	TORN VINYL:						
		4 p.m. R43's wheelchair was					
		roken vinyl on the left arm at 10:30 a.m. environmental					
		nance-A verified the left arm					
		yl and the arm rest was not a					
	cleanable surface.						
	On 12/16/13 at 5.02	2 p.m. R32's electric scooter					
		ve duct tape covering half of					
		nd to have a chunk of cushion					
		corner of right arm rest. On					
		.m. environmental director verified the above and					
		est was not a cleanable					
	surface.						
	The facility Mhaalah	air Maching roport chaota					
	dated for 11/25/13, 2	air Washing report sheets					
		cumentation of repairs					
	needed for R32's ele	ectric scooter or R43's					
	wheelchair.						
	The facility Maintena	ance Repair Request sheets					
	dated from 8/25/13 1	through 12/15/13, had no					
	documentation of re	pairs reported for R32's					
	electric scooter or R	43's wheelchair.					
	On 12/18/13. at 10.3	30 a.m. environmental director					D. 0938-0391 ATE SURVEY DMPLETED 2/19/2013
		ent had their own personal					

Facility ID: 00672

If continuation sheet Page 21 of 25

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	r			T	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245345	B. WING		MM Dept of Health	12/	/19/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDC	RE HEALTH CENTER	R OF GREENWOOD PRAIRIE			00 SECOND AVENUE NORTHWEST LAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	to get parts and rep equipment was not were done, the facil equipment for the re director stated house cleaning wheelchair cleaned weekly. En- housekeeping would weekly report sheet down repairs neede stated housekeepin down the repairs neede stated housekeepin down the repairs neede stated housekeepin down the repairs neede located in the nurse On 12/18/13, at 11: <sup>-</sup> verified R32's electr covering half of righ cushion was missing arm rest. The house surface was not a cl director verified hou for washing wheelch housekeeping staff a repairs needed on w washing report sheet further stated house retrained what write On 12/18/13, at 12:0 (DON) stated she wi repairs needed to be and the repairs to be should be cleanable personal scooter sho able to replaced ther	ded repair, the facility needed air it. The director stated if the able to be used until repairs ity would provide appropriate esident. Environmental sekeeping was responsible for rs and all wheelchairs were vironmental director stated d fill out a wheelchair washing , which had an area to write ed. Environmental director g should also have written reded in the fix it report book report room. 10 a.m. housekeeping director ic scooter had duct tape t arm rest and a chunk of g from back corner of right ekeeping director verified the leanable. Housekeeping sekeeping was responsible hairs weekly and stated should have reported the vheelchairs on the wheelchair et. The housekeeping director keeping staff needed to be	F 4	65			

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			F		01/16/2014 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		0		0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		245345	B. WING			12	/19/2013
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISID	ORE HEALTH CENTER	OF GREENWOOD PRAIRIE			300 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	undated, read "Star system to monitor a and transmission of proper cleaning and Policy: The wheelch each resident will be needed to ensure cl maintenance if need TILES, REGISTERS SURFACES NOT IN The facility failed to registers, wooden si rooms/bathrooms in R56 and R54's shar a.m. bathroom ceilin appearing as water bed scraped area. R36's room on 12/1' ceiling tile had disco water staining and w large area that appe R19's room and R57 p.m. radiator had mu broken. On 12/18/13 had been observed. R3's room on 12/16/ multiple scratches. O had a missing piece R1's room on 12/16/ multiple scratches w	idard: There is an organized nd prevent the development nosocomial infections thru maintenance of equipment. airs and assisted devices for e cleaned weekly and as eanliness. Please notify ded supplies." S, WALLS AND WOODEN UTACT: maintain ceiling tiles, urfaces and walls in resident	F 4	465			

Facility ID: 00672

If continuation sheet Page 23 of 25

		AND HUMAN SERVICES					FORM	): 01/16/2014 1 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	0	(X3) DAT	TE SURVEY MPLETED
		245345	B. WING	i			12	/19/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP		•	
ST ISIDC	ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE			800 SECOND AVENUE NORTHWES PLAINVIEW, MN 55964	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 465	Continued From pa	ge 23	F،	465	5			
		32's room on 12/17/13, at 9:44 door had scratches.						
	a.m., with environm maintenance (maint been observed and director stated he has the above needing r stated staff were to it report book locate and the fix it book w repairs needed. Env maintenance was re checked the book d stated as preventive report book "we do r month" to identify ar Environmental direc ceilings had not bee would have to be ad	al tour on 12/18/13, at 10:01 ental director and tenance-A) the above had verified. Environmental ad not been aware of any of repair. Environmental director write repairs needed in the fix d in the nurse report room tas for all staff to report vironmental director stated esponsible for repairs and aily. Environmental director e maintenance beyond the rounds in the facility once per ny other repairs needed. tor stated radiators and in items checked on rounds, ided to the list. At 1:00 p.m. tor stated registers were and they were not scheduled						
	dated from 8/25/13 t	ance Repair Request sheets hrough 12/15/13, had no served repairs needed for d resident rooms.						
	dated 9/09, read, "M Factors: The building and kept free of haza by any damaged or or operating systems electrical, communic	ance Department Policies aintenance and Repair g is maintained in good repair ards such as those created defective parts of the building s such as plumbing, ations, heating and cooling, tate and local codes and						

Facility ID: 00672

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		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245345	B. WING	;		12	19/2013
NAME OF F	PROVIDER OR SUPPLIER	<b>1</b>		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDO	RE HEALTH CENTER	R OF GREENWOOD PRAIRIE			0 SECOND AVENUE NORTHWEST AINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	services are to be p categories: Electric appliances. Mechar furniture, appliance	e repair and maintenance performed in the following al systems, equipment and nical repair of equipment, s. Wall cleaning, ceiling shing or redecorating; heavy	F	465			

Event ID: 8EZ111

Facility ID: 00672

If continuation sheet Page 25 of 25

ND PLAN (	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245345	B. WING		12	/18/2013
AME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CO	DE	10/2015
T ISIDO	RE HEALTH CENTER	OF GREENWOOD PRAIRIE	80	00 SECOND AVENUE NORTHWEST		
			P	LAINVIEW, MN 55964		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	FIRE SAFETY THE FACILITY'S PC ALLEGATION OF C DEPARTMENT'S AC SIGNATURE AT TH PAGE OF THE CMS VERIFICATION OF UPON RECEIPT OF ON-SITE REVISIT C CONDUCTED TO V SUBSTANTIAL COM REGULATIONS HAS ACCORDANCE WIT A Life Safety Code S Minnesota Departme Fire Marshal Division St. Isidore Health Ce was found not in sub requirements for par Medicare/Medicaid a 483.70(a), Life Safet edition of National Fi	DC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR E BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE. FAN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION. Survey was conducted by the ent of Public Safety - State At the time of this survey, enter of Greenwood Prairie stantial compliance with the ticipation in t 42 CFR, Subpart y from Fire, and the 2000 re Protection Association 1, Life Safety Code (LSC).	K 000	The submission of this response correction is not to be construed a admission that a deficiency exists statement of deficiency was correct Preparation and submission of the correction does not constitute an agreement of any kind by the faci- of any facts alleged or the correct conclusions set forth in the allega survey agency. Preparation and se of this plan of correction has been comply with the requirements of se federal law that mandate submiss Plan of Correction within ten (10) receipt of the statement of deficie condition of participation in Title 1 programs. The plan of correction letter of credible allegation of com CORPORTING STREAM STREAM STREAM CORPORTS STREAM STREAM STREAM CORPORTS STREAM	as a legal s or that this ectly cited. is plan of admission or ility to the truth tness of any ttion by the submission n done to state and sion of a days of the ncies as a 8 and Title 19 is the facility's	
	PLEASE RETURN T CORRECTION FOR DEFICIENCIES ( K-TAGS) TO:	HE PLAN OF THE FIRE SAFETY		FEB - 7 2014	Y	
	Health Care Fire Insp State Fire Marshal Di	vision		STATE FIRE MARSHAL DIVISIO		
ATORY	DIRECTOR'S OR BROVIDE	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		

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 program participation.

		AND HUMAN SERVICES				FORM	01/08/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245345	B. WING	i		12/ <sup>.</sup>	18/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDO	DRE HEALTH CENTER	R OF GREENWOOD PRAIRIE			300 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	THE PLAN OF COD DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre This facility will be a buildings. St. Isidor Prairie is a 2-story b at 2 different times. constructed in 1968 Type II(222) constru- constructed to the S be of Type II(222) of two buildings are of and meet the const existing buildings, t building. The facility is fully s fire alarm system w detection and spac- monitored for autor notification.	Suite 145 -5145, or .Whitney@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency.	K	000			

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES			FORM A	01/08/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>	(X3) DATE COMP	SURVEY
		245345	B. WING		12/1	8/2013
	PROVIDER OR SUPPLIER	R OF GREENWOOD PRAIRIE		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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K 144 SS=F	NOT MET as evide NFPA 101 LIFE SA Generators are insp	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD pected weekly and exercised ninutes per month in	K 14	4		
	accordance with NF	-FA 99. 3.4.4.1.				
	Based on documer interview, the facilit emergency generat requirements of 200	s not met as evidenced by: ntation review and staff y failed to inspect the tor in accordance with the 00 NFPA 101 - 9.1.3 and 1999 ne deficient practice could nts.				
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	12/18/2013, docum visual inspection er (December 2012 to	veen 1:30 PM and 3:30 PM on entation review of the weekly nergency generator testing log o December 2013), indicated ergency generator visual sed for 02/04/2013.				
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If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	01/16/2014 APPROVED 0938-0391
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		245345	B. WING	÷		12/	18/2013
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					See Bldg 2 for POC		1/28/14
	*TEAM COMPOSIT Gary Schroeder, Lif						
	2						

Event ID: 8EZ121

Facility ID: 00672

If continuation sheet Page 4 of 4

DEPARTMENT OF DEPICIENCIES DEPRETATION OF CORRECTION CENTERS FOR MEDICARE & MEDICAID BERVICES STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES STATEMENT OF DEPICIENCIES STATEMENT OF CORRECTION DESTINATION NUMBER 245345 STIBORE HEALTH CENTER OF GREENWOOD PRAIRIE SUMMARY STATEMENT OF DEFICIENCIES STIBORE HEALTH CENTER OF GREENWOOD PRAIRIE SUMMARY STATEMENT OF DEFICIENCIES STIBORE HEALTH CENTER OF GREENWOOD PRAIRIE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES THE SUMMARY STATEMENT OF DEFICIENCIES FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEFACTORMECTION AS THE PRECEDED OF THE DEFACTORMECTION OF COMPLIANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CONSTIC OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATIAL COMPLIANCE. WITH YOUR VERIFICATION. ALTE Safety Code SURVY was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division At the time of this Survy, St. Isidore Health Care. PLEASE RETURN THE PUSCIONS ASTATE REVISION ALTHE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division A the time of this Survy, St. Isidore HEALTH CONST IN 55 SUPPART MARY DEFICIENCIES (K-TAGS) TO: HEALTH OF THE PUSCIONS STATE FIRE MARSHAL DIVISION ADDATION POSTORY ORESOND SUBSTANTIAL COMPANY AS DECOMPANY AND			AND HUMAN SERVICES		I	FERLICIO		: 01/16/2014 APPROVED
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Jaula & Flick		Janla X II	inter 1			11 min dontre	11	5.1.
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that	Ny deficienc	y statement ending with	masterisk (*) denotes a deficiency whi	ch the inc	titutiz	on may be excused from portrait		+0/2014

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

		AND HUMAN SERVICES				FORM	01/16/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 02 - CHAPEL	(X3) DAT	E SURVEY PLETED
		245345	B. WING	_		12/	18/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ISIDO	RE HEALTH CENTER	R OF GREENWOOD PRAIRIE		L	800 SECOND AVENUE NORTHWEST		
					PLAINVIEW, MN 55964		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K	000	5		
	By email to: Marian	.Whitney@state.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION:					
	1. A description of v to correct the defici	vhat has been, or will be, done ency.			5		
	2. The actual, or pro	oposed, completion date.					
		r title of the person ection and monitoring to ence of the deficiency.					
	buildings. St. Isidore Prairie, 2005 additio	surveyed as two separate e Health Center of Greenwood on is a 2-story building. The determined to be of Type II					
	fire alarm system w detection and space	prinklered. The facility has a ith full corridor smoke es open to the corridors that is natic fire department					
	The facility has a ca census of 49 at the	apacity of 53 beds and had a time of the survey.					
K 144 SS=F	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 1	144	1		
	Generators are insp	ected weekly and exercised					

Facility ID: 00672

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	AND HUMAN SERVICES			C	FORM	01/16/2014 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	245345	B. WING			12/	18/2013
PROVIDER OR SUPPLIER	•	4	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	10/2013
ORE HEALTH CENTER	R OF GREENWOOD PRAIRIE					
			PI			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
under load for 30 m	ninutes per month in	K 1	44	be completed weekly as required. Maint	enance	1/28/2014
Based on documer interview, the facility emergency generat requirements of 200 NFPA 110 6-4.1. Th	ntation review and staff y failed to inspect the for in accordance with the DO NFPA 101 - 9.1.3 and 1999 the deficient practice could					
Findings include:						
12/18/2013, docum visual inspection en (December 2012 to that the weekly eme	entation review of the weekly nergency generator testing log December 2013), indicated ergency generator visual			,		
This deficient practi facility maintenance discovery.	ce was confirmed by the staff (JL) at the time of					
	This STANDARD is Based on documer interview, the facility emergency generat requirements of 200 NFPA 110 6-4.1. Th affect all 49 residen Findings include: On facility tour betw 12/18/2013, docum visual inspection en (December 2012 to that the weekly eme inspection was miss This deficient practi facility maintenance discovery.	DEF CORRECTION       IDENTIFICATION NUMBER:         245345         PROVIDER OR SUPPLIER         DRE HEALTH CENTER OF GREENWOOD PRAIRIE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 2 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.         This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.1. The deficient practice could affect all 49 residents.         Findings include:       On facility tour between 1:30 PM and 3:30 PM on 12/18/2013, documentation review of the weekly visual inspection emergency generator visual inspection was missed for 02/04/2013.         This deficient practice was confirmed by the facility maintenance staff (JL) at the time of discovery.         *TEAM COMPOSITION*	TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MUL         DENTIFICATION NUMBER:       (X2) MUL         PROVIDER OR SUPPLIER       245345       B. WING         DRE HEALTH CENTER OF GREENWOOD PRAIRIE       ID       PREFICIENCY MUST BE PRECEDED BY FULL       REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 2       under load for 30 minutes per month in accordance with NFPA 99.       3.4.4.1.       K 1         This STANDARD is not met as evidenced by:       Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999       NFPA 110 6-4.1. The deficient practice could affect all 49 residents.         Findings include:       On facility tour between 1:30 PM and 3:30 PM on 12/18/2013, documentation review of the weekly visual inspection emergency generator visual inspection emergency generator visual inspection emergency generator visual inspection was missed for 02/04/2013.         This deficient practice was confirmed by the facility maintenance staff (JL) at the time of discovery.         *TEAM COMPOSITION*	TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPL         DENTIFICATION NUMBER:       A. BUILDING         245345       B. WING         PROVIDER OR SUPPLIER       S         DRE HEALTH CENTER OF GREENWOOD PRAIRIE       P         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 2 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.       K 144         This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.1. The deficient practice could affect all 49 residents.         Findings include:       On facility tour between 1:30 PM and 3:30 PM on 12/18/2013, documentation review of the weekly visual inspection emergency generator testing log (December 2012 to December 2013), indicated that the weekly emergency generator visual inspection was missed for 02/04/2013.         This deficient practice was confirmed by the facility maintenance staff (JL) at the time of discovery.	IT OF DEFICIENCIES       (X1) PROVIDERSUPPLIENCIA.       (X2) MULTIPLE CONSTRUCTION         DEP CORRECTION       245345       B. WNG         PROVIDER OR SUPPLIER       245345       B. WNG         DRE HEALTH CENTER OF GREENWOOD PRAIRIE       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       DREFIGURY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREVIDERS PLANOF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY         Continued From page 2 under load for 30 minutes per month in accordance with NFPA 99.       X.4.1.       It ae emergency generator visual inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.1. The deficient practice could affect all 49 residents.       K 144       The emergency generator using log (December 2012 to December 2013), indicated that the weakly emergency generator visual inspection was missed for 02/04/2013.         This deficient practice was confirmed by the facility maintenance staff (JL) at the time of discovery.       The AMPOSITION*	HSP FOR MEDICARE & MEDICAD SERVICES       OMB NO.         OF OPERIEENCIES       (Y) PROVIDERSUPPLIENCIA IDENTIFICATION NUMBER       (X3) DAT COM         245345       B. WING       12/         PROVIDER OR SUPPLIER       STREET ADDRESS. CITY, STATE, 2P CODE 800 SECOND AVENUE NORTHWEST PLAINVEW, MN 55964       12/         SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)       IP REFIX TAG       PROVIDERS PLAN OF CORRECTION (EACH ORDER THE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 2 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.       K 144       The emergency generator is monthor, supervisor responsible. Administrator to monitor,         This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator is accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.1. The deficient practice could affect all 49 residents.         Findings include:       On facility tour between 1:30 PM and 3:30 PM on 12/18/2013, documentation review of the weekly visual inspection emergency generator visual inspection was missed for 02/04/2013.         This deficient practice was confirmed by the facility maintenance staff (JL) at the time of discovery.       Index

Facility ID: 00672

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Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7002 0860 0006 5192 3902

January 16, 2014

Ms. Paula Lewis, Administrator St Isidore Health Center Of Greenwood Prairie 800 Second Avenue Northwest Plainview, Minnesota 55964

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5345023

Dear Ms. Lewis:

The above facility was surveyed on December 16, 2013 through December 19, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

St Isidore Health Center Of Greenwood Prairie January 16, 2014 Page 2

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

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

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

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

Sincerely,

Mark meath

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5345s14.rtf

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00672	B. WING		12/19/2013		
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·		
	E HEALTH CENTER OF	GREENWOOD PRA	OND AVENUE NOI EW, MN 55964	RTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET		
2 000	Initial Comments		2 000				
	****ATTEN	ITION*****					
	NH LICENSING C	ORRECTION ORDER					
	144A.10, this correct pursuant to a survey found that the deficie herein are not correct not corrected shall be with a schedule of fin the Minnesota Depar Determination of whe corrected requires corr requirements of the r number and MN Rule	ether a violation has been					
	lack of compliance. I re-inspection with an result in the assessm	e items will be considered Lack of compliance upon y item of multi-part rule will ent of a fine even if the item ing the initial inspection was					
	that may result from orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.					
	of this Department's provider and the follo issued. When correct sign and date on the the line marked with	5: 7, 18 and 19, 2013, surveyors staff visited the above wing licensing orders were tions are completed, please bottom of the first page in "Laboratory Director's or presentative's signature."		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to Minnesota state statutes/rules for Nu Homes.	)		

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

TITLE

(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00672	B. WING		12/19/2013	
		800 SEC	DDRESS, CITY, ST.			
SI ISIDOF	RE HEALTH CENTER OF	GREENWOOD PRA PLAINVI	EW, MN 55964			
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2 000	Continued From page	e 1	2 000			
	return the original to Minnesota Departme	nt of Health SE, Rochester, MN 55904.		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings wh are in violation of the state statute after statement, "This Rule is not met as evidenced by." Following the survey findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	." e)/rule e)/rule nich er the ors f G OF IIS	
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and ; General	2 830			
	receive nursing care custodial care, and s individual needs and the comprehensive re plan of care as desc 4658.0405. A nursin	eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out ossible unless there is a				

STATE FORM

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00672	B. WING		12	12/19/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
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2 830	Continued From page	e 2	2 830				
		e attending physician that the n in bed or the resident bed.					
	by: Based on observation review, the facility fai of 3 residents (R36) a investigate, assess, a promote healing and	nt is not met as evidenced n, interview and document led to identify a bruise for 1 and the facility failed to and develop interventions to prevent bruising from residents (R6) reviewed for skin conditions.					
	Findings include:						
	have a dark purple di skin of the right temp documented evidenc identified, ongoing as develop interventions	n 12/16/13, at 3:50 p.m. to iscolored area located on the le. The clinical record lacked e the discoloration had been ssessment for healing, and based on a comprehensive nt bruising from reoccurring.					
	indicated R36 had dia dementia, anxiety an indicated R36 had se	d heart disease. The MDS evere cognitive impairment R36's care plan dated 6 as having a risk for					
	indicated on 11/29/13 unwitnessed fall. Alti identified R36 had a	nursing progress notes 3, R36 had sustained an hough the progress note bump on the right forehead d, the clinical record lacked					

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2 830	Continued From page	e 3	2 830				
	documentation the br the area monitored fo complications.	uise had been identified and or healing without					
	(DON) verified the brit temple of R36 and re- and confirmed R36 has her head. DON verified had not been identified DON stated when a fa- in an injury, DON exp monitoring event" in t to ensure monitoring DON verified the mor created nor was the b The Skin Risk Assess directed staff to note or presence of bruise R6 had a bruise locat had not been reported assessed for causal f	sment policy dated 7/2013, and document the absence is. ted on the right hand which d to licensed staff, factors, or interventions put					
	bruising. R6 was observed on have a purple colored between the second thand. R6 wore an ort	ealing and prevent further 12/16/13, at 6:05 p.m. to d, quarter-sized bruise finger and thumb on the right hotic device which covered said he was not able to tell uise happened.					
	the hand to wrist orth bruise on the right ha Velcro from the right l	6 a.m. R6 was observed with otic on the right hand. The nd was covered by the hand orthotic. At the time of tated the bruised area					

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2 830	Continued From page	e 4	2 830					
	10/13/13, indicated R failure, hypertension, and hemiplegia of the Assessment (CAA) d Braden score (a tool skin breakdown) was at risk for skin breakdown indicated R6's BIMS indicated R6's BIMS indicated R6 continue cognitive impairment required extensive as staff, R6 did not walk mechanical lift) for tra extensive assist of or R6's physician's order range of motion (ROI before applying the o special instructions in the orthotic on at nigh during the day. The of meals and activities. included medications which include Couma							
	identified R6 also had brace. The care plan around the orthotic b	d a foot brace and right arm directed to observe the skin races and during cares for areas, including bruises.						
noosta Da	On 12/18/13, at 10:4 (RN)-A, licensed prac DON were interviewe all verified they were confirmed there was	1 a.m. registered nurse ctical nurse (LPN)-C and ed. RN-A, DON and LPN-C not aware of the bruise and						

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2 830	Continued From page	e 5	2 830			
	right hand. At the time visually observed the between the thumb a stated it did not look I loosened the orthotic now. At 10:45 a.m. LI at 3.5 centimeter (cm nursing assistants (N order was verified by they were not sure of assessed the orthotic the NA should have r	oncerning the bruise on R6's e of the interview, RN-A bruise on the right hand nd the second finger and ike an old bruise. RN-A and R6 stated it felt better PN-C measured the bruise ) x 3.0 cm and stated the As) applied the orthotic. The LPN-C and RN-A stated the last time therapy had the RN-A and LPN-C stated eported the bruise and a m should have been started				
	indicated the bruise w hand, included the ob- identified R6 was on the strap on the ortho- been "too tight." LPN- instructed to make su nurses' note written b intervention on 12/19	on 12/18/13, at 11:17 a.m. vas noted on R6's right otained measurements, Coumadin, had thin skin and tic hand brace may have -C indicated staff would be the strap was loose. A by RN-A after surveyor /13, at 8:28 a.m. noted R6's as checked. RN-A noted the				
	nurse. DON stated th monitoring event in th stated the nurse wou	a.m. DON stated she report the bruise to the e nurse would then open a ne clinical record. DON Id also email the DON if the le or call the DON if it was				
	The facility's Monitori Incidents/Accidents p directed nursing staff					

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2 830	Continued From pag	e 6	2 830			
	incidents/accidents ir record under "Events	n the computerized medical s."				
	injuries policy dated a skin tears, scratches not the result of a spor reported to the nursir injury was noted. The nurse would then eva- the resident if approp were to be document record and the care p SUGGEST METHOE director of nursing or to comprehensively a implement interventio provided care in a ma well-being. A monitor	D FOR CORRECTION: The designee could direct staff assess residents, and ons to ensure residents are anor to promote their highest ring program could be to assure ongoing ctive care plan interventions				
21426	(21) days.	CORRECTION: Twenty one	21426			
	(a) A nursing home maintain a comprehe infection control prog current tuberculosis i issued by the United Control and Preventi Tuberculosis Elimina	rol provider must establish and				

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If continuation sheet 7 of 20

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00672	B. WING		12/19/2013	
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21426	Continued From page	e 7	21426			
	unpaid employees, c residents, and volunt Health shall provide t regarding implement	that covers all paid and ontractors, students, eers. The Department of technical assistance ation of the guidelines.				
	by:					
	licensed practical nur TB education for staf On 12/19/13, at 8:18 have not been doing nursing assistants an the only staff receiving	a 12/18/13, at 3:30 p.m. rse (LPN)-B stated the last f had been done in 7/2012. a.m. LPN-B stated, "We all staff TB education, nd licensed staff have been ng education for TB." LPN-B identified all employees I education.				
	6/7/12, identified nurs attendance sheets da	g attendance sheets dated sing assistants; the ated 6/21/13, identified only en educated regarding TB.				
nnesota Dep	dated 7/31/13, read, employees at this fac education appropriate	Control TB Control Plan "VI. HCW Education 1. All cility will receive annual e to their tasks regarding TB; s will be given as needed."				

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21426	Continued From page 8		21426			
	The director of nursin responsible for TB ec hires and asess if the	OD OF CORRECTION: og could in-service staff lucation to educate new ere is a need to do annually. CORRECTION: Twenty One				
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General		21535			
	must be free from un unnecessary drug is a A. in excessive d therapy; B. for excessive C. without adequ D. in the presence which indicate the do discontinued. In addition to the dru part 4658.1310, the with provisions in the Code of Federal Reg 483.25 (1) found in A Operations Manual, C Long-Term Care Faci Department of Health Health Care Financin This standard is income available through the	any drug when used: lose, including duplicate drug duration; late indications for its use; or ce of adverse consequences se should be reduced or g regimen review required in nursing home must comply Interpretive Guidelines for ulations, title 42, section ppendix P of the State Guidance to Surveyors for lities, published by the n and Human Services, g Administration, April 1992. rporated by reference. It is Minitex interlibrary loan Law Library. It is not				
	This MN Requiremen	t is not met as evidenced				

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21535	Continued From pag	e 9	21535			
	review, the facility fa (R28) was comprehe use of side rails; faile Findings include: R2	n, interview and document iled to ensure 1 of 4 residents ensively assessed for safe ed to identify . 8 was not comprehensively e use of half (½) side rail on				
	10/27/13, identified F impaired, required ex for bed mobility, tran had behaviors. Use o on the MDS.	num Data (MDS) dated R28 was severely cognitively xtensive assist of one staff sferring and ambulation; R28 of side rails was not triggered • p.m. a one half-length side				
	rail was observed on	the bed was pushed next to				
	the low bed sleeping was up and the bed	a.m. R28 was observed in on her back. The side rail remained next to the wall. At ned in bed sleeping and the				
	EquipmentSide rail R28 would use the to medical symptom for weakness and indica rail was to assist R22 mobility. The form in were explained to R2 7/28/13. The assess	sment for Restraint/Adaptive s dated 7/23/13; identified op two half side rails. The r use of the side rails was ated the reason for the side 8 with transferring and bed dicated the risks and benefits 28 and their family on ment did not address R28's				
	approaches attempte Note dated 10/27/13	include the alternative ed. A Quarterly Progress , indicated R28 "continues to e rails for T&R [turning and				

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21535	Continued From page	e 10	21535			
	repositioning]."					
	(DON) and registered interviewed regarding indicated R28 had no and indicated every s	R28's use of side rail. Both incidents with the side rail ide rail was reviewed for they were used for and the				
	regarding R28 's side stated staff goes in an bed boundaries, or tra assessment in the co safety and stated safe to the side rail assess quarterly reviews wer was a change in the r verified nothing else h	a.m. RN-A was interviewed e rail assessment. RN-A nd checks for bed mobility, ansfers. RN-A stated the mputer had not addressed ety should have been added sment. RN-A stated the re not changed unless there resident. RN-A further had been documented in of the side rail for R28.				
	Facility policy for Side indicated side rails we restraints and side ra assessed for proper u directed, "Safety of th for bed mobility must are in place." The pro staff was expected to safety methods and o physical restraint was limited to bolster pillo	e Rail Usage dated 7/2013 ere considered to be il use would be individually usage. The procedure he resident using side rails be observed while the rails ocedure indicated nursing consider all alternative care approaches before a utilized, such as, but not ws, floor bed mats, personal ed snacks and toileting, and				
	-	r tract infections (UTIs) were ntial risk factor for falls.				
	R36's Current ICD_9	Diagnoses dated as printed				

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	Continued From page 11 12/18/13 included chronic kidney disease with a history of urinary tract infections (UTI) and falls. Review of incident report documentation from 8/05/13, to 12/16/13, revealed R36 experienced falls on 8/5/13, 11/9/13, 11/24/13, 11/29/13, and 12/13/13. Of the five falls, three identified R36 had been treated for a UTI, and one identified R36 had been monitored for UTI symptoms. The facility's "Fall Risk (Acuity)" assessment form dated 9/23/12 indicated R36 had a history of falls with risk factors that included incontinence. The assessment identified R36 as being at high risk for falls related to confusion and not always aware of safety. The annual Minimum Data Set (MDS) dated 9/27/13, indicated R36 had a Brief Interview for Mental Status (BIMS, a tool used to determine cognitive loss) score of three out of 15, which indicated severe cognitive impairment. The MDS					
	one staff for transfers frequently incontinent toileting program to r The MDS identified F with no injury since a Assessment (CAA) in aware of the need to toilet. The care plan dated being at high risk for	at of urine and was not on a manage urinary incontinence. R36 had experienced one fall admission. The Care Area dentified R36 had been urinate and took self to the 10/2/13, identified R36 as falls however, did not				
	falls which included l which may contribute further falls and poss	a.m. RN-A reported the fall				

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21535	Continued From page	e 12	21535			
	interventions for UTIs were to be included on the care plan. RN-A verified R36's chronic UTIs had not been fully assessed in relation to R36 's fall history.					
	fall risk documentatio chronic UTIs. DON ve for and/or monitored	a.m. the DON verified the n should have included erified R36 had been treated for UTI symptoms which four of the last five falls.				
	dated 7/2013, identifi responsible for review	Accidents/Incidents policy ed the charge nurse was ving occurrences for risk appropriate interventions.				
	director of nursing or all staff responsible for	OD OF CORRECTION: The pharmacist could in-service or medication use on the uirements as written under				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One				
21695	MN Rule 4658.1415 Housekeeping, Opera	-	21695			
F r c c a	provide housekeepin necessary to maintain comfortable interior, i	bing. A nursing home must g and maintenance services n a clean, orderly, and ncluding walls, floors, tures, equipment, lighting,				
	by:	t is not met as evidenced				
	Based on observation	n, interview and document				

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TATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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21695	Continued From page 13		21695			
	equipment in sanitary residents (R43, R32); environment in good rooms (R56, R54, R3 R32) reviewed. Findings Include: ELECTRIC SCOOTE TORN VINYL: On 12/16/13, at 3:04 observed to have bro rest. On 12/18/13, at director and maintena	led to maintain resident care //good repair for 2 of 2 ; failed to maintain physical repair for 9 of 24 resident 16, R19, R57, R3, R1, R33, ER AND WHEELCHAIR p.m. R43's wheelchair was ken vinyl on the left arm 10:30 a.m. environmental ance-A verified the left arm and the arm rest was not a				
	cleanable surface. On 12/16/13, at 5:02 was observed to have the right arm rest and missing from back co 12/18/13, at 10:30 a.r and maintenance-A v	p.m. R32's electric scooter e duct tape covering half of t to have a chunk of cushion rner of right arm rest. On m. environmental director rerified the above and st was not a cleanable				
	dated for 11/25/13, 12	umentation of repairs				
	dated from 8/25/13 th	nce Repair Request sheets rough 12/15/13, had no airs reported for R32's 3's wheelchair.				
		) a.m. environmental director nt had their own personal				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00672	B. WING		12	2/19/2013	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
T ISIDOR	E HEALTH CENTER OF	GREENWOOD PRA	OND AVENUE NOF EW, MN 55964	THWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21695	Continued From page 14		21695				
	to get parts and repai equipment was not al were done, the facility equipment for the res director stated house cleaning wheelchairs cleaned weekly. Envi housekeeping would weekly report sheet, w down repairs needed stated housekeeping	keeping was responsible for and all wheelchairs were ronmental director stated fill out a wheelchair washing which had an area to write . Environmental director should also have written ded in the fix it report book					
	verified R32's electric covering half of right a cushion was missing arm rest. The housek surface was not a cle director verified house for washing wheelcha housekeeping staff sh repairs needed on wh washing report sheet.	nould have reported the neelchairs on the wheelchair . The housekeeping director eeping staff needed to be					
	(DON) stated she wor repairs needed to be and the repairs to be should be cleanable. personal scooter shou able to replaced then	-					
	resident wheelchair a	he facility policy for cleaning nd assisted devices ard: There is an organized					

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			
		00672	B. WING		12	2/19/2013
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
	RE HEALTH CENTER OF	GREENWOOD PRA	OND AVENUE NOR EW, MN 55964	THWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page 15 system to monitor and prevent the development and transmission of nosocomial infections thru proper cleaning and maintenance of equipment. Policy: The wheelchairs and assisted devices for each resident will be cleaned weekly and as needed to ensure cleanliness. Please notify maintenance if needed supplies." TILES, REGISTERS, WALLS AND WOODEN SURFACES NOT INTACT: The facility failed to maintain ceiling tiles, registers, wooden surfaces and walls in resident rooms/bathrooms in good repair.		21695			
	a.m. bathroom ceiling	d room on 12/17/13, at 9:42 g tile had discolored area taining and wall beam above				
	ceiling tile had discolo water staining and wa	/13, at 9:31 a.m. bathroom ored areas appearing as all beam above bed had ared as water staining .				
	p.m. radiator had mul	s room on 12/16/13, at 4:06 Itiple scratches and was at 10:01 a.m., the same				
	multiple scratches. O the same had been o	3, at 2:36 p.m. radiator had n 12/18/13, at 10:01 a.m., bserved and the radiator over a split in the radiator.				
		3, at 3:48 p.m. radiator had th rust noted and wooden nultiple chips of wood				
	R33's Room and R32	2's room on 12/17/13, at 9:44				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00070	B. WING		40/40/2040	
	ROVIDER OR SUPPLIER	00672	ADDRESS, CITY, STATE		12	/19/2013
		800 SEC				
T ISIDOF	RE HEALTH CENTER OI	F GREENWOOD PRA	IEW, MN 55964			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLE DATE
21695	Continued From pag	je 16	21695			
	a.m. wooden closet	door had scratches.				
	During environmental tour on 12/18/13, at 10:01 a.m., with environmental director and maintenance (maintenance-A) the above had been observed and verified. Environmental director stated he had not been aware of any of the above needing repair. Environmental director stated staff were to write repairs needed in the fix it report book located in the nurse report room and the fix it book was for all staff to report repairs needed. Environmental director stated maintenance was responsible for repairs and checked the book daily. Environmental director stated as preventive maintenance beyond the report book "we do rounds in the facility once per month" to identify any other repairs needed. Environmental director stated radiators and ceilings had not been items checked on rounds, would have to be added to the list. At 1:00 p.m. environmental director stated registers were painted as needed and they were not scheduled to be painted.					
	dated from 8/25/13 t	ance Repair Request sheets hrough 12/15/13, had no served repairs needed for d resident rooms.				
	dated 9/09, read, "M Factors: The building and kept free of haza by any damaged or o or operating systems electrical, communic	ance Department Policies laintenance and Repair g is maintained in good repair ards such as those created defective parts of the building s such as plumbing, cations, heating and cooling, tate and local codes and				
nesota Der	regulations. Routine services are to be pe	repair and maintenance erformed in the following I systems, equipment and				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00672	B. WING		12/19/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ST ISIDOF	RE HEALTH CENTER OF	GREENWOOD PRA	OND AVENUE NOR EW, MN 55964	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	furniture, appliances. cleaning, and refinish duty floor cleaning an SUGGESTED METH administrator, environ (s) could revise polici that the environment hazards, safe, function comfortable for the rea The administrator, en designee (s) could pri related how to ensure policies and procedu administrator, environ (s) could monitor the conditions periodical	cal repair of equipment, Wall cleaning, ceiling ning or redecorating; heavy nd resurfacing." IOD OF CORRECTION: The nmental director or designee ies and procedures to ensure for the residents is free from	21695			
21942	(21) days.	CORRECTION: Twenty One 10 Subd. 8b Establish Councils	21942			
	Resident advisory co boarding care home advisory council and fewer than three pers participating. If one o function, the nursing home shall documen council or councils at year. This subdivision	uncil. Each nursing home or shall establish a resident a family council, unless sons express an interest in r both councils do not home or boarding care t its attempts to establish the e least once each calendar n does not alter the rights of s provided by section				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00672			12/19/2013		
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE			
T ISIDOR	E HEALTH CENTER OF	GREENWOOD PRA		THWEST			
	SI IMMARY ST		EW, MN 55964	PROVIDER'S PLAN		(X5)	
PREFIX (EACH DEFICIENCY M		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	SHOULD BE COMPLE	
21942	Continued From page	2 18	21942				
	This MN Requiremen	t is not met as evidenced					
	by:						
	Based on interview and document review, the facility failed to promote the development of a						
	family council group on an annual basis. This had the potential to affect all 48 residents residing in the facility.						
	Findings include:						
	The facility failed to continue attempts to establish a family council.						
	facility information reg group or attempts to a The administrator pro	vey team requested from the garding a family council establish a family council. wided a copy of an undated nembers on admission.					
	reported the facility a	p.m. the administrator dmission packet included a					
	residents to join a fan	d the family council had met					
	reported housekeepir responsible for the fa	ng staff (HS)-A had been					
	unable to provide nar	nes of family members that					
		en HS-A. The administrator rs and friends of residents					
	had been invited to jo	in family council during the owever no attempts had					
	been made after adm	-					
	On 12/19/13, at 10:15 facility did not have a	5 a.m. HS-A verified the					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/19/2013	
		00672				
ame of Pf	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
T ISIDOF	RE HEALTH CENTER OF	GREENWOOD PRA	EW, MN 55964			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21942	Continued From page	e 19	21942			
	further verified no attempts had been made to contact family members annually to establish a family council.					
	administrator and or or efforts to form a famil	OD OF CORRECTION: The designee could ensure that ly council were completed ent family members and or				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One				